
# Annual Report on Implementation of Acute and Long-Term Services and Supports System Redesign for Individuals with Intellectual and Developmental Disabilities

**As Required By**
**S.B. 7, 83rd Legislature, Regular Session, 2013 and**
**H.B. 3523, 84th Legislature, Regular Session, 2015**

**Health and Human Services Commission**
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## 1. Executive Summary

House Bill (H.B.) 3523, 84th Legislature, Regular Session, 2015, builds on requirements that were outlined in Senate Bill (S.B.) 7, 83rd Legislature, Regular Session, 2013. S.B. 7 continued previous legislative efforts to improve quality and outcomes in the Texas Medicaid program with an emphasis on improving the long-term services and supports (LTSS) system for individuals with intellectual and developmental disabilities (IDD).

To address the ongoing need for LTSS, S.B. 7 redesigned the Medicaid LTSS system for individuals with IDD as well as for low-income seniors and individuals with physical disabilities.

S.B. 7 established the IDD System Redesign Advisory Committee (SRAC) to work in consultation with the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS) to implement the S.B. 7 provisions affecting individuals with IDD.

S.B. 7 required improved coordination and efficiency of Medicaid LTSS with acute care services and directed HHSC to redesign the delivery system of LTSS serving individuals with IDD. On September 1, 2014, individuals with IDD in an IDD waiver (Community Living Assistance and Support Services (CLASS), Home and Community-based Services (HCS), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD)) or in community-based intermediate care facilities for individuals with an intellectual disability or related condition (ICF-IID), transitioned from Medicaid fee-for-service (FFS) into managed care for acute care services. Individuals with both Medicare and Medicaid (individuals who are dually eligible) were excluded, and children under the age of 21 were voluntary. Since July 2015, an average of 39,042 individuals are enrolled in an IDD waiver or community based ICF-IID each month. In August 2015, there were 17,577 individuals enrolled in STAR+PLUS for acute care services who lived in a community-based ICF-IID or who received services through an IDD waiver. Of the 17,577 individuals with IDD enrolled in STAR+PLUS, 504 were children age 21 and younger, and 17,187 were adults (age 21 years or older).

S.B. 7 also directed HHSC to establish the STAR Kids Medicaid managed care program for children with disabilities and complex care needs. HHSC established the STAR Kids Managed Care Advisory Committee, required by the legislation, and coordinated with the Children's Policy Council in the development of STAR Kids. Beginning November 1, 2016, approximately 180,000 children and young adults with disabilities, including those with IDD, will receive their Medicaid acute care services through one of ten STAR Kids managed care organizations (MCOs) around the state. Children and young adults in a nursing facility, community-based ICF-IID, or IDD waiver program will continue to receive their facility and waiver services as they did prior to November 1, 2016, but their acute care, behavioral health, and pharmacy services will be delivered by the MCO of their choice. All other children and young adults, including those enrolled in the Medically Dependent Children Program (MDCP) waiver will receive coordinated acute and LTSS through their MCO.

S.B. 7 directed HHSC to implement the most cost-effective option for the delivery of basic attendant and habilitation services to individuals with disabilities and to maximize federal

funding. Community First Choice (CFC) is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities who meet an institutional level of care. After receiving approval from the Centers for Medicare & Medicaid Services (CMS), HHSC implemented CFC on June 1, 2015.

S.B. 7 directed HHSC to adopt rules allowing for additional housing supports for individuals with disabilities, including individuals with IDD. HHSC and DADS continue to work with partner agencies to increase options for community-based housing that permit individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences. A subcommittee of the IDD SRAC has been created to explore and recommend additional housing supports for the IDD community.

S.B. 7 authorized HHSC and DADS to develop and implement pilot program(s) to test one or more service delivery models involving a managed care strategy based on capitation to deliver Medicaid LTSS to individuals with IDD. H.B. 3523 required the pilot(s) be implemented by September 1, 2017, and expanded the qualified entities for delivery of the pilot to include MCOs in addition to private service providers. The pilot(s) must be designed to increase access to LTSS, improve quality of acute care services and LTSS, and promote efficiency and the best use of funding. In January 2015, HHSC hosted four public forums in Houston, San Antonio, Lubbock and Fort Worth and held two webinars. A fifth public forum was held in Austin in March 2016. In April 2015, HHSC surveyed the IDD SRAC on the development and structure of the pilot program. HHSC developed and posted a request for information (RFI) on July 20, 2015. Responses were received in August 2015, and HHSC used the responses to identify next steps for implementation of the pilot. The request for proposals for the pilot itself is expected to be released in the fall of 2016.

Subject to the availability of federal funding, S.B. 7 directed DADS to develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with IDD and behavioral health needs who are at risk of institutionalization. A number of projects relating to behavioral health intervention have been approved for funding through HHSC's 1115 Healthcare Transformation Waiver and are in various stages of implementation. Additionally, the Money Follows the Person (MFP) Rebalancing Demonstration Grant funds supported the development of an online web-based training system designed for direct service workers across long-term services in community-based settings, focused on the behavioral health needs of individuals with IDD who have challenging behaviors. MFPD rebalancing funds also finance Positive Behavior Management and Supports Workshops to teach strategies and techniques for the prevention and management of challenging behaviors exhibited by individuals diagnosed with an intellectual disability. MFPD funds will support the creation of eight local medical, behavioral, and psychiatric teams and enhanced community coordination.

This report does not include specific recommendations from the state for the Legislature; however, the report appendix includes recommendations received from the IDD SRAC. The current statute defines the next steps in the redesign process, and HHSC and DADS continue to move forward with implementation of the projects described in this report. The report also was

drafted prior to the transformation of the health and human services system. Many of the activities DADS was directed to do are now being carried out by HHSC.

## 2. Introduction

The goals of the system redesign outlined in S.B. 7 are to design and implement an acute care services and LTSS system for individuals with IDD that:

- Provides Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs;
- Improves individuals' access to services and supports by ensuring individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and educating individuals on how to apply for the programs and services;
- Improves the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs;
- Promotes person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;
- Promotes individualized budgeting based on an assessment of an individual's needs and person-centered planning;
- Promotes integrated service coordination of acute care services and LTSS;
- Improves acute care and LTSS outcomes, including reducing unnecessary institutionalization and potentially preventable events;
- Promotes high-quality care;
- Provides fair hearing and appeals processes in accordance with applicable federal law;
- Ensures the availability of a local safety net provider and local safety net services;
- Promotes independent service coordination and independent ombudsmen services; and
- Ensures individuals with the most significant needs are appropriately served in the community and processes are in place to prevent inappropriate institutionalization of individuals.

S.B. 7 directed HHSC to report annually to the Legislature on implementation of the Medicaid acute care services and LTSS delivery system for individuals with IDD. H.B 3523 further expanded the reporting requirements. Implementation activities began in September 2013 and the full redesign will roll out gradually through 2021. STAR Kids will serve children with IDD, but the components outlined below describe other aspects of the LTSS system for people with IDD.

The delivery system components addressed in S.B. 7, excluding STAR Kids, include:

- Requiring all individuals with disabilities who are eligible for Medicaid acute care services to receive those services in a coordinated manner through a managed care plan;
- Providing basic attendant and habilitation services to eligible individuals with disabilities who are currently waiting for services;
- Implementing a new functional assessment instrument to more accurately assess the needs of individuals with IDD;
- Establishing behavioral supports to help individuals with IDD avoid institutionalization;
- Establishing a long-term plan for piloting and delivering services for individuals with IDD through managed care; and
- Allowing for the development of additional housing supports for individuals with disabilities.

S.B. 7 also established the IDD SRAC to work in consultation with HHSC and DADS to implement the provisions affecting individuals with IDD. Although some of the requirements below were previously required of HHSC, H.B. 3523 expanded the role of the IDD SRAC to consult and collaborate with HHSC and DADS on the following:

- Identifying private service providers or MCOs to implement the pilot program;
- Evaluating proposals submitted by private service providers and MCOs to determine if the private service providers and MCOs have the ability to provide LTSS to individuals that will receive services through the pilot program;
- Analyzing information provided during the operation of the pilot for purposes of making recommendations about future systems or programs;
- Preparing and submitting a report to the Legislature;
- Reviewing and evaluating the progress and outcomes of each pilot program implemented as part of the annual report that must be submitted to the Legislature;
- Developing the transition plan for transitioning the provision of Medicaid benefits between a Medicaid waiver program or an ICF-IID program and a pilot program to protect continuity of care;
- Analyzing the outcomes of providing acute care Medicaid benefits to individuals with IDD under the pilot;
- Developing a process to receive and evaluate input from interested statewide stakeholders on the transition of TxHmL into managed care;
- Ensuring there is a comprehensive plan for transitioning the provision of TxHmL to managed care; and
- Analyzing the outcomes of the transition of the LTSS under TxHmL to a managed care program delivery model.

HHSC must ensure integrity and mitigate potential conflicts of interest in the procurement process. Because the IDD SRAC membership includes providers, provider associations, and MCO representation, HHSC determined it was not appropriate for the committee to be involved in the following aspects of the pilot under HB 3523:

- Identifying private service providers or MCOs that are good candidates to develop a service delivery model involving a managed care strategy;
- Evaluating each submitted managed care strategy proposal and determining whether the proposal demonstrates the ability to provide LTSS appropriate to the individuals who will receive services through the pilot program; and
- Assisting in the development of a request for proposals (RFP) or any components of an RFP, including developing a tool in which HHSC would determine the pilot vendor(s).

The advisory committee consists of 26 members representing various communities of interest (see Appendix A). The committee held its initial meeting in January 2014 to discuss the Legislature's intent and establish committee goals. Since the initial meeting, the committee continues to meet on a quarterly basis. As part of its work, the IDD SRAC submitted recommendations to the HHSC Executive Commissioner regarding the Network Access Improvement Projects (NAIP) for individuals with IDD (Appendix B), developed 20 legislative appropriations request recommendations (Appendix C), submitted these requests to the appropriate agencies for consideration, and created recommendations on how to make the STAR+PLUS enrollment packet more user friendly (Appendix D). The 20 legislative appropriations requests were sent to DADS, HHSC, the Department of Assistive and

Rehabilitative Services (DARS), and the Texas Department of Housing and Community Affairs (TDHCA).

The IDD SRAC established five subcommittees:

- Housing
- Assessment
- Transition to managed care
- Day habilitation and employment services
- Quality

The housing subcommittee continues to focus on supporting the development of affordable, accessible, and integrated housing for individuals with IDD. The housing subcommittee created legislative appropriations request recommendations. These recommendations were approved by the full committee and included in the 20 legislative appropriations request recommendations submitted to DADS, HHSC, and TDHCA for consideration (Appendix C).

The assessment subcommittee was established to focus on the goal of implementing a new functional assessment instrument to more accurately assess the needs of individuals with IDD. In late 2014, this subcommittee provided DADS and HHSC with feedback on the assessment tools being considered and feedback on the design of the IDD assessment pilot. This subcommittee is not meeting currently due to the confidentiality requirements of the RFP process.

The transition to managed care subcommittee focuses on the various transition activities outlined in S.B. 7 and H.B 3523, makes recommendations, and identifies areas for system improvements. The transition to managed care subcommittee made recommendations that were adopted by the full IDD SRAC related to making the STAR+PLUS enrollment packet more user friendly. The recommendations are contained in Appendix D.

The quality subcommittee continues to address planning, development, and implementation of a quality strategy for acute care services and LTSS provided under the Medicaid program to individuals with IDD and makes recommendations to the full committee for ongoing quality and system improvements. The quality subcommittee has focused on making a user-friendly guide related to who an individual should contact to obtain help. In addition to monitoring person-centered planning approaches and training, the quality subcommittee is developing recommendations for additional training for STAR+PLUS service coordinators working with individuals with IDD. This subcommittee voted to support the recommendation of the Children's Policy Council to reduce the Medically Dependent Children Program (MDCP) interest list by allowing all children and young adults up to age 21 who receive supplemental security income and meet MDCP waiver eligibility to automatically receive MDCP services without spending time on the interest list (Appendix E).

The day habilitation and employment services subcommittee held its initial meeting on October 28, 2015, and continues to look at recommendations for improvement to day habilitation and employment services.

# 3. Implementation Activities

## 3.1 Delivery of Acute Care Medicaid Services Through Managed Care

On September 1, 2014, as directed by S.B. 7, individuals enrolled in HCS, TxHmL, CLASS, DBMD and community-based ICF-IIDs transitioned from traditional Medicaid FFS into the STAR+PLUS Medicaid managed care program for acute care services. Individuals enrolled in STAR+PLUS have a service coordinator employed by the MCO to assist in the appropriate and timely provision of acute care services. Every member was assigned an MCO service coordinator. The number of required visits and level of service coordination for each individual varies by acuity and the member's or their legally authorized representative's personal preference.

Individuals served in state supported living centers (SSLCs) and individuals who receive Medicare Part B benefits in addition to Medicaid (known as full dual eligibles), were excluded from this carve-in. Children and young adults age 20 and younger enrolled in these programs who do not receive Medicare Part B benefits can elect to enroll in STAR+PLUS or remain in traditional Medicaid.

On November 1, 2016, individuals age 20 and younger with IDD enrolled in HCS, TxHmL, CLASS, DBMD and community-based ICF-IIDs, including full dual eligibles, will transition from traditional Medicaid FFS or STAR+PLUS into the new STAR Kids Medicaid managed care program. STAR Kids will be tailored to the needs of youth and children with disabilities. STAR Kids will provide service coordination, which will help identify needs and connect members to services and qualified providers. The level of service coordination will vary based on the needs of the member and personal preference of the member or their legally authorized representative. Each member will have their service needs assessed, which will form the basis of that member's individual service plan. Additionally, STAR Kids will provide transition planning for members starting at age 15 to prepare the member and their family for the transition to adulthood. Transition planning becomes more intensive as the member prepares to turn 21 and transition to an adult Medicaid program, like STAR+PLUS.

*Current Status*

Individuals with IDD who transitioned into managed care continue to receive their LTSS services, including CFC services, from their waiver or ICF-IID provider and their acute care through the STAR+PLUS program, and after November 1, 2016, STAR Kids program. In addition to the MCO service coordinator, these individuals also have an LTSS case manager, service coordinator or qualified intellectual and developmental disability professional (QIDP), depending on the program from which the individual receives services, who assists the individual with developing and implementing the LTSS service plan and monitoring the LTSS service delivery. HHSC encourages ongoing communication among all of these parties to ensure coordination of the individual's LTSS and acute care services.

*Education and Outreach*

In the fall of 2013, HHSC created an IDD Managed Care Improvement Workgroup to discuss the MCO and LTSS providers' responsibilities, identify stakeholders' educational needs, review training materials and make suggestions to promote a smooth transition for individuals with IDD into STAR+PLUS. The workgroup is composed of representatives from advocacy agencies, LTSS provider agencies, local intellectual and developmental disability authorities (LIDDAs), and other agencies that provide service coordination/case management, MCOs, the managed care enrollment broker (MAXIMUS), DADS, and HHSC. The workgroup provided valuable review and feedback on a number of operational issues and continued to meet on a quarterly basis to address issues and challenges as it relates to the carve-in and system redesign activities. HHSC has implemented a number of the recommendations in response to feedback received from the workgroup. In May 2016, the workgroup's members agreed to terminate the workgroup, as they determined the items of discussion and membership overlapped with many of the IDD SRAC subcommittees. HHSC will ensure workgroup membership is aware of public IDD SRAC meetings.

Other opportunities for ongoing stakeholder involvement include the bi-monthly DADS IDD System Improvement Workgroup meetings, quarterly Promoting Independence Advisory Committee (PIAC) meetings, quarterly IDD SRAC meetings, and the IDD transition to managed care subcommittee meetings.

HHSC Program Support and Utilization Review conducted a series of webinar-based trainings between February and April 2016 for MCO service coordinators. Subjects included nursing assessments, CFC, transitions to adult programs for children, and other important topics. The webinars are archived for MCO service coordinators to access in the future.

Throughout 2016, HHSC staff conducted face to face information sessions across the state to educate families, MCOs, and providers on the implementation of STAR Kids.

*Network Adequacy*

All Medicaid MCOs are required to have an adequate network to serve members. Despite contracting efforts by the MCOs, all providers who serve members in the FFS system may not want to participate in managed care, or may not want to open their panels to a large number of members. To address this issue, during the transition into managed care, MCOs worked closely with physicians and arranged single case agreements or closed panels, which allow physicians to contract with the MCOs to serve specific members instead of providing services to the entire membership. MCOs report establishing 94 of these agreements to ensure continuity of care since September 1, 2014, with 50 agreements remaining active as of April 30, 2016. Reasons provided for termination of agreements included the member no longer needed the provider or facility's services and the provider joined the MCOs' networks. Additionally, the MCO service coordinators are required to assist their members with locating providers. HHSC continues to provide education to individuals and their legally authorized representatives around the service coordinators' role in locating providers.

S.B. 760, 84th Legislature, Regular Session, 2015, requires MCO monitoring of provider networks to ensure MCOs provide members sufficient access to Medicaid providers and services. The bill requires HHSC to:

- Develop, collect and report data regarding network adequacy;
- Require MCOs to assign initial and subsequent primary care physician (PCP) providers;
- Ensure STAR+PLUS members receive paper directories unless they opt-out of receiving them;
- Identify provider types that qualify for expedited credentialing and include requirements in managed care contracts; and
- Develop methodology to collect data on open panels and appointment wait times.

HHSC held a public forum on November 30, 2015, to collect feedback on changes stakeholders would like made to MCO provider networks. Input received at the forum was reviewed by HHSC staff and used to develop draft proposals for revising provider access standards, improving provider directories, and identifying provider types for expedited credentialing.

HHSC held a second stakeholder meeting on June 6, 2016, to discuss and receive public input on the agency's draft proposals. Healthcare and dental provider groups, MCOs, and members of the public were invited to participate in the stakeholder meeting to discuss how best to strengthen MCO provider networks and implement provisions of S.B. 760, including setting standards for network adequacy. Feedback received from the second stakeholder forum will be used to make changes to the draft proposals and to inform agency leadership on next steps. Once standards are established, HHSC will submit to the Legislature a report containing information on Medicaid members' access to healthcare services in managed care. This report will also be publically available.

*Challenges*

- Access to specialists (particularly psychiatrists, gastroenterologists, and podiatrists) and primary care physicians for individuals with IDD: Access to specialists continues to be a challenge in Texas Medicaid and is not limited to managed care. HHSC and the MCOs continue to work with stakeholders to address this issue.
- Coordination between MCO service coordinators and waiver service coordinators, case managers, or QIDPs: HHSC and DADS continue to encourage the MCO service coordinators and waiver service coordinators, case managers, and QIDPs to maintain open communication to assist individuals with coordinating their services. The IDD Managed Care Improvement Workgroup has helped facilitate better communication between providers, families, and other parties. Additionally, although not directly related to the carve-in, the MCOs and the Texas Council of Community Centers started meeting regularly in September 2014, which has resulted in better and more open communication between the MCOs and LIDDAs.
- Coordination of individuals leaving a SSLC to transition into the community from FFS institutional Medicaid to managed care community Medicaid: when an individual has complex medical needs, the coordination of Medicaid as they transition into the community has proven to be a challenge with ensuring coordination of care. HHSC and DADS

developed a process involving coordination among DADS, HHSC, and the MCO to expedite these types of cases.

*Successes*

- Continued collaboration between the stakeholders, MCOs, LIDDAs, and providers. The IDD Managed Care Improvement Workgroup created an opportunity for the IDD stakeholders, MCOs, LIDDAs, and providers to all work collaboratively.
- Expanded service array: Individuals enrolled in managed care now have access to additional services. In STAR+PLUS, individuals have an MCO service coordinator for their acute care needs. This allows for additional coordination between the waiver service coordinator, case manager or QIDP and the MCO service coordinator. Additionally, individuals have access to value added services[1]. Individuals also have the opportunity to receive additional services that the MCOs may authorize on a case-by-case basis that are above and beyond the standard Medicaid benefits or value-added services. Case-by-case services may be based on medical necessity, cost-effectiveness, the wishes of the individual/individual's family, the potential for improved health status of the individual, or functional necessity.
- Individuals meeting both medical necessity (MN) and ICF-IID level of care (LOC) criteria have the opportunity to choose between the STAR+PLUS waiver and an IDD waiver, depending on which waiver best meets their needs. HHSC and DADS continue to work with the LIDDAs and MCOs to ensure individuals know their options and are able to make an informed choice based on the services and benefits available in each program.
- Lessons learned during the IDD acute care carve-in are being applied to the implementation of STAR Kids.

*Fair Hearing Data*

Since the acute care carve-in on September 1, 2014, the five STAR+PLUS plans reported the following appeals data specific to acute care services for members with IDD from August 1, 2015, through April 30, 2016.

**Table 1: Fair Hearing Data**

| Total number of acute care appeals for members with IDD | Total number of appeals upheld by MCO | Total number of appeals overturned by MCO | Total number of appeals withdrawn | Total number of pending appeals |
|---|---|---|---|---|
| 10 | 3 | 0 | 7 | 0 |

[1] Value added services are services offered by the MCOs that are above and beyond the Medicaid benefits, and not included in capitation payments to the MCOs (thus not paid for with Medicaid dollars). Examples of value added services include a 24-hour nurse line, additional dental and vision benefits beyond the Medicaid benefits offered, and pest control services. Not all MCOs offer the same value added services and the MCOs pay for the services.

STAR+PLUS plans reported the following types of fair hearings:

- Denial of durable medical equipment
- Denial of physical therapy services
- Denial of occupational therapy services
- Denial of inpatient hospital or psychiatric stay

*Complaint Data*

HHSC's Health Plan Management (HPM) unit tracks complaints received from members, legally authorized representatives or family members, provider agencies, and other interested entities. Individuals are encouraged initially to contact the MCO directly to resolve the complaint, prior to contacting HPM for assistance. Individuals also may contact the Ombudsman's office. HHSC continues to educate individuals and providers on the complaint process. Since August 1, 2015, HPM received fewer than 15 complaints for individuals with IDD receiving managed care. As of October 25, 2016, one complaint was substantiated[1], twelve were unsubstantiated and one complaint is pending. This number is based on complaints that were submitted to HPM by an individual, legally authorized representative or family member, provider, advocate, stakeholder, or state employee. Complaints received outside of this process are not reflected in the total.

HPM has tracked the following types of complaints from members with IDD:

- Access to care
- Benefits issues (denials, communication about benefits provided, updating provider)
- Claims issues (denials, delayed payments, underpayments)
- Ineffective communication
- In network specialty care/provider access

Additionally, MCOs must develop, implement, and maintain a system for tracking, resolving, and reporting member complaints regarding its services, processes, procedures, and staff. MCOs reported receiving 105 complaints for individuals with IDD since August 2015, including the following types of complaints:

- Access to care (specialist care, pharmacy, durable medical equipment, primary care providers
- Delay of authorization, treatment and referral
- Benefit not covered
- Quality of MCO services
- Quality of provider services
- Billing issues (provider billing MCO, balance billing)

[1] A substantiated complaint is one in which HPM's research indicates agency policy was violated or agency expectations were not met (e.g., paying at an incorrect rate, member not receiving benefits).

## 3.2 Community First Choice (CFC)

S.B. 7 required HHSC to implement basic attendant and habilitation services for individuals with disabilities, maximizing federal funding for the delivery of these services. HHSC responded by creating the CFC benefit, utilizing the 1915(k) Medicaid state plan option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. The CFC benefit was implemented on June 1, 2015. The state receives a six percent increased federal match for CFC services.

Individuals may be eligible for CFC services if they:

- Are eligible for Medicaid;
- Meet an institutional LOC; and
- Have functional needs that can be addressed by CFC services.

CFC services include:

- Personal assistance services
- Habilitation services
- Emergency response services
- Support management

CFC services are provided in home or community-based settings and not in nursing facilities, hospitals providing long-term services, institutions for mental disease, ICF-IIDs, or a setting with the characteristics of an institution. CFC services are not time or age limited and continue as long as eligible individuals reside in their own home or family home settings and needs are present. CFC services are provided by LTSS providers including home and community support services agencies and waiver providers.

S.B. 7 directed DADS to contract with LIDDAs to provide IDD service coordination, provide assessments to MCOs, assist in the development of plans of care, and coordinate with MCOs and DADS regarding recommended plans of care for CFC services. S.B. 7 (Texas Government Code 534.152) restricts LIDDAs that provide service coordination from providing attendant or habilitation services. LIDDAs provide LOC determinations for individuals that might meet an ICF-IID LOC and functional needs assessments for potentially-eligible individuals.

*Current Status*

MCOs are working together with the LIDDAs to provide CFC services to STAR+PLUS members who have IDD or are on an interest lists for HCS, CLASS, TxHmL, or DBMD. HHSC, DADS, LIDDAs, and MCOs developed a plan to begin CFC outreach efforts with individuals already on an interest list for these IDD waivers who are Medicaid eligible but not yet receiving any Medicaid LTSS. The LIDDAs and MCOs were provided with a list of individuals to prioritize outreach. HHSC anticipates an average of 10,000 individuals on an interest list for IDD waivers will receive CFC services each month in fiscal year (FY) 2016, and this number is forecasted to increase yearly. Individuals enrolled in HCS, CLASS, TxHmL or DBMD and

receiving acute care services through STAR+PLUS receive their CFC services through their waiver provider and not through their MCO.

STAR+PLUS and STAR Health MCOs are also offering CFC services to new members of any age who ask for or are identified as potentially benefiting from CFC services, and they are offering CFC services to existing members in STAR+PLUS and STAR Health at the member's next reassessment contact.

The CFC benefit for children in the FFS delivery system is managed in a way that parallels the process used for personal care services (PCS). The Department of State Health Services (DSHS), through regional case management staff[2], provides a front door for new individuals and individuals currently receiving PCS who request CFC.

CFC was also implemented in the four IDD waiver programs (HCS, TxHmL, CLASS, and DBMD). These waivers include habilitation as a benefit. Since habilitation is now a CFC service available as a state plan benefit, individuals receiving these services through a waiver transitioned to receive these services as CFC on June 1, 2015. Since transportation was a component of the waiver habilitation benefit and is not part of the CFC benefit, transportation continues to be provided as a waiver service. On March 20, 2016, Texas Administrative Code rules for HCS, TxHmL, CLASS, and DBMD were updated to include CFC.

As CFC approached one year of implementation, HHSC finalized processes, policies, and communication with DADS, LIDDAs, the Texas Council of Community Centers, and MCOs for reassessment of an individual's level of care and reassessment of CFC services. Working with subject matter experts at DADS and the LIDDAs, HHSC is working to implement forms to aid MCOs in monitoring the delivery and quality of habilitation services, including how a provider is working with an MCO's member to meet the member's goals, identified in the CFC assessment and person-centered service planning process. HHSC anticipates 59,400 individuals will receive CFC each month of FY 2016 with an estimated net general revenue impact of $54.8 million.

HHSC began in-depth discussions with STAR Kids MCOs about CFC in March 2016. This work has continued and includes ensuring appropriate processes and procedures related to children's eligibility assessments and service planning are in place by the November 1, 2016, STAR Kids implementation date. Processes involving LIDDAs, local mental health authorities (LMHAs), and referrals for assessments and annual reassessments for an ICF-IID or IMD LOC have been finalized and written into policy. The functional CFC assessment was built into the STAR Kids screening and assessment instrument, creating a seamless assessment for not only CFC but other services and supports identified in the global assessment of a STAR Kids member's medical and functional needs.

The 2016-17 General Appropriations Act, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 77), appropriated funds to provide non-medical transportation and respite for adults with IDD in STAR+PLUS. HHSC is currently analyzing how to best implement these services.

[2] Effective September 1, 2016, DSHS case management staff are part of the Medical and Social Services Division of HHSC.

Additional information about CFC can be found in the *Report on Implementation of Basic Attendant Care and Habilitation for Individuals with Intellectual and Developmental Disabilities in STAR+PLUS* submitted to the Texas Legislature in July 2016.

*Education and Outreach*

HHSC, DADS, and DSHS staff provided training and information in a wide variety of forums in the year leading up to the implementation of CFC. These sessions gave stakeholders a chance to provide input and gain valuable information about the CFC benefit. More importantly, these meetings provided state staff an opportunity to hear the concerns about the CFC rollout from providers, individuals, parents, legally authorized representatives, and other stakeholders. The meetings varied in scope and included provider training, program presentations, beneficiary and parent outreach, and workgroups.

In addition to in-person meetings, HHSC maintains a CFC website. The site includes information on eligibility, benefits and services, provider information, and contact information for questions. DSHS and DADS also created brochures to educate individuals about the CFC benefit, as well as information letters to help providers navigate the new world of CFC. These documents were distributed to stakeholders and are posted on the websites.

HHSC and DADS periodically conduct webinars to educate the public on updates to CFC. During 2016, webinars were held on:

- March 17 (amendments to CLASS & DBMD program rules)
- March 21 (on amendments to HCS & TxHmL program rules)
- March 23 (on federal HCBS rules for provider self-assessments)

The PowerPoint presentations and recordings for each of these webinars have been posted to the HHSC website.

In addition to the webinars, HHSC and DADS staff presented about CFC at the HCS and TxHmL waiver conference held on April 27, 2016. HHSC and DADS have provided additional presentations at the request of stakeholders. Finally, a computer based training on Form 8510 (HCS/TxHmL CFC Personal Assistance Services (PAS)/Habilitation (HAB) Assessment) was launched in March 2016.

*Assessment*

Effective March 20, 2016, DADS implemented a new assessment to more consistently determine the number of CFC PAS/HAB hours required to meet the goals identified in an individual's person-directed plan. Completion of Form 8510 (HCS/TxHmL CFC PAS/HAB Assessment) is part of the person-centered planning process; the form asks detailed questions about the individual's needs. Since parts of this assessment are already used for individuals receiving non-waiver CFC services, adding the assessment will make CFC implementation consistent for individuals receiving CFC through HCS and TxHmL as well.

*Person-centered Planning*

HCBS federal rules applying to home and community-based services, including CFC, require the services to be provided through a person-centered framework. Texas proposed, and CMS approved, a person-centered planning process and required components of the person-centered service plan. Details on the process and plan requirements are included in the Medicaid State Plan and the CFC rules, and the state developed a functional assessment that incorporates person-centered planning principles.

A person-centered plan identifies the strengths, preferences, needs (clinical and support) and goals of an individual, and balances what is important *to* a person with what is important *for* the person. Person-centered planning touches on non-clinical areas such as relationships, community participation, employment, finances, wellness, and education.

HHSC requires all individuals who are responsible for facilitating a person-centered service plan for CFC services to obtain HHSC-approved training in person-centered thinking within two years of CFC implementation (by June 1, 2017), or within two years of hire if the hire date is after June 1, 2015.

HHSC and DADS[3] have established a cross-agency workgroup to identify opportunities to offer the training around the state in different formats and venues to ensure everyone who needs it has access to it. This workgroup will also establish ways to ensure quality person-centered service planning is being delivered consistently across the system of home and community-based services. Once the training requirements are fully implemented, the state will look toward infusing person-centered practices through all levels of home and community-based service delivery.

*Challenges*

- Educating stakeholders and individuals about the intricacies of CFC: A great deal of education was required and is still ongoing to ensure individuals understand the services available to them and the means by which they will receive these services. The state worked closely with stakeholders, provider groups, advisory committees, the LIDDAs, MCOs, and many other organizations and individuals with an interest in CFC to provide information on the benefit. All of these groups were instrumental in partnering with the state to provide education about this new benefit.
- Ensuring individuals who qualify for CFC have timely access to the new entitlement benefits, which are available to anyone who qualifies: CFC can provide services to a large number of people in Texas who were not receiving LTSS benefits prior to implementation. Most of these individuals require outreach by the LIDDAs. The LIDDAs have competing and limited resources to dedicate to this amount of outreach.

[3] Effective September 1, 2016, DADS staff participating in this workgroup are employees of HHSC.

- Implementing the same benefit across service delivery models, many of which already included CFC-like benefits, added to the intricacies of CFC and the audience-specific educational needs of individuals and providers.
- Accessing non-medical transportation continues to be a concern for individuals receiving CFC who are not enrolled in one of the IDD waivers.

*Successes*

- HHSC is providing services to individuals who did not have access to LTSS prior to CFC, some of whom have been waiting on an interest list for waiver services for many years.
- In close collaboration with our federal partners, Texas received approval to implement the new CFC benefit. Texas is one of five states to offer CFC services.
- Texas was able to use an existing provider base and infrastructure, since all of the services offered through CFC were already available in the state through various avenues. For example, habilitation is an integral service offered through all of the IDD waivers, so in implementing CFC, the state was able to use that same provider base to deliver CFC habilitation. The state was also able to leverage existing tools to create the functional needs assessment.
- CFC has fostered closer collaboration between multiple entities (e.g., health and human services agencies, LIDDAs, MCOs, providers, and stakeholders) that have not always worked together.
- A workgroup has been meeting on a regular basis to discuss stakeholder concerns regarding the CFC PAS/HAB assessment (Form 8510). This group plans to present suggestions and to work with HHSC to implement necessary changes to the tool, as well as the corresponding form used in STAR+PLUS.
- HHSC is using lessons learned from the implementation of CFC as part of the STAR Kids implementation on November 1, 2016.
- HHSC continues to collaborate with stakeholders, including other state agencies and contracted partners, provider organizations, advocates, and individuals receiving CFC services, to improve the delivery system and ensure consistent information is available to the public. This collaboration has been invaluable for identifying and resolving systemic issues.

## 3.3 IDD Comprehensive Assessment Pilot

S.B. 7 directed DADS to develop and implement a comprehensive assessment instrument and a resource allocation process for individuals with IDD, as needed, to ensure each individual with IDD receives the appropriate type, intensity, and range of services based on the functional needs of that individual. The current assessment is the Inventory for Client and Agency Planning (ICAP), which focuses on deficits and does not directly assess strengths, resulting in inferences being made to determine supports needed. Additionally, while the ICAP collects information about formal supports, it does not collect information about the availability of natural supports (e.g., unpaid caregivers, such as family members, friends, and neighbors). Another concern with the ICAP is that the associated resource allocation does not adequately tie resources to an individual's identified need. A new assessment process is expected to more effectively consider individuals' needs and available supports and ensure individuals receive the precise scope, amount, and duration of services they require without receiving services they do not need.

DADS staff analyzed nationally recognized comprehensive assessment instruments for individuals with IDD and solicited stakeholder input on elements that should be included within a comprehensive assessment. Staff also interviewed other states' health and human services agencies about their assessment instruments. Information from this review was shared with the PIAC and the IDD SRAC.

In August 2014, DADS posted an RFI to solicit information from vendors about assessment instruments or inter-related groups of assessment instruments for populations including individuals with IDD. Two of the four responses met the RFI's specifications. The International Resident Assessment Instrument (interRAI) Intellectual Disability (ID) was found to best meet S.B. 7 specifications and requests received from external stakeholders. The interRAI suite of assessments has the capability to accommodate ongoing system reform as it contains multiple assessment instruments for populations both with and without intellectual disabilities (ID), including adults with ID, acute care, adult mental health, home care, long-term care facilities, palliative care, and the child and youth ID and mental health assessment tools slated for release in 2015. The final determination to pilot the interRAI ID assessment was made in April 2015. In July 2015 some stakeholders requested the scope of the pilot be expanded to include other interRAI instruments in addition to the interRAI ID assessment. However, in order to complete a direct comparison of the current assessment instruments with another instrument developed specifically for individuals with IDD, the pilot will encompass only the interRAI ID. Other assessments included in the suite may be considered following the completion of the pilot.

*Current Status*

On March 21, 2016, DADS posted an RFP to solicit vendors to assist the state in implementing the pilot. Pilot activities will begin during the current biennium. These activities will include completion of the interRAI ID assessment on a sample population in an identified geographic region of the state. HHSC is working to publish an RFP to solicit a vendor to analyze the results of the pilot. This analysis will assist the state in determining future assessment rollout activities.

## 3.4 Flexible Low-cost Housing

S.B. 7 directed HHSC to adopt rules allowing for additional housing supports for individuals with disabilities, including individuals with IDD. These additional housing supports include community housing options that comprise a continuum of integration that permits individuals to select the most integrated and least restrictive setting appropriate to the individual’s needs and preferences, including:

- Provider owned and non-provider owned residential settings
- Assistance with living more independently
- Rental properties with onsite supports

S.B. 7 directed DADS, TDHCA, the Department of Agriculture (TDA), the Texas State Affordable Housing Corporation (TSAHC), and the IDD SRAC to coordinate with public

housing entities to expand opportunities for accessible, affordable, and integrated housing to meet the complex needs of individuals with disabilities.

In June 2015, CMS issued an informational bulletin on Medicaid coverage of housing-related activities for persons with disabilities. Texas offers many of the housing-related support service options outlined in the bulletin and is reviewing the additional options in the bulletin.

*Current Status*

HHSC and DADS continue to work with partner agencies to increase options for community-based housing that permit individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences. One example of this cross-agency collaboration involves the Section 811 Project Rental Assistance (PRA) program, which provides project-based rental assistance linked with long-term services and supports for individuals with extremely low-incomes and disabilities. The program is made possible through a partnership between TDHCA, HHSC, and eligible multifamily properties. TDHCA was awarded approximately $12.3 million from the U. S. Housing and Urban Development (HUD) Fiscal Year 2012 Section 811 Project Rental Assistance Demonstration Program and $12 million from HUD's Fiscal Year 2013 Section 811 PRA Program. The Section 811 PRA program creates the opportunity for persons with disabilities to live as independently as possible through the coordination of voluntary services and a choice of subsidized, integrated rental housing options. The Texas Health and Human Services (HHS) system provides service coordination and supportive services to eligible participants and TDHCA manages the funds and the wait list for the rental properties.

Eligible populations include:

- Individuals with IDD and other disabilities who are exiting institutions and eligible for Medicaid
- Individuals with severe mental illness who are eligible for services through DSHS[4]
- Youth and young adults with disabilities aging out of foster care

TDHCA placed two points in its 2015 Qualified Allocation Plan (QAP) for those who submitted an application for low income housing tax credits (LIHTC) and agreed to participate in the Section 811 PRA program. A total of 18 properties (a combination of existing and new) are participating because of the 2015 LIHTC cycle. TDHCA staff and HHS staff are conducting trainings for local service providers and coordinators, as well as property managers of participating properties, in counties across the state that have participating properties. Properties are completing their necessary TDHCA and HUD startup steps and waiting lists for properties are being generated. TDHCA published a request for applications announcement and is accepting applications from eligible properties not seeking low income housing tax credits. The 2016 QAP includes continuing tax credit incentives for applicants participating in the Section 811 PRA.

[4] As of September 1, 2016, this division of DSHS is part of HHSC.

## 3.5 IDD Managed Care Pilots

S.B. 7 directed HHSC and DADS to develop and implement a pilot program to test one or more service delivery models using a managed care strategy based on capitation to deliver Medicaid LTSS to individuals with IDD. H.B. 3523 delayed implementation of the pilot from September 1, 2016 until September 1, 2017.

S.B. 7 and H.B. 3523 requires the pilot to:

- Increase access to LTSS;
- Improve quality of acute care services and LTSS;
- Promote meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion;
- Promote integrated service coordination of acute care services and LTSS;
- Promote efficiency and the best use of funding;
- Promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;
- Promote employment assistance and customized, integrated, and competitive employment;
- Provide fair hearing and appeals processes in accordance with applicable federal law; and
- Promote sufficient flexibility to achieve these goals.

*Current Status*

In April 2015, HHSC issued a survey to the IDD SRAC to allow committee members to provide feedback on pilot development and structure. On July 20, 2015, HHSC issued an RFI and used the responses to identify next steps. HHSC posted a draft RFP on May 2, 2016. HHSC is reviewing feedback received to finalize the RFP. HHSC will issue an RFP to solicit vendors to operate the IDD managed care pilots in the fall of 2016.

## 4. Serving Individuals with Significant Needs in the Community

There is a clearly recognized need to develop stronger capacity within the community-based long-term services and supports system to support individuals with IDD who have high medical needs (HMN) and want to live in the community. DADS is working in concert with a HMN workgroup which included external stakeholders to improve overall system capacity to serve individuals with high medical needs. The initiative consists of two primary efforts focused initially on individuals leaving an SSLC. Part one of the initiative focuses on creating opportunities for individuals with HMN to move to small ICF-IIDs from SSLCs. Part two of the initiative is exploring expanded service capacity within the HCS waiver program to meet the needs of these individuals once they are able to enroll in the waiver.

## 5. Behavioral Supports for Individuals with Intellectual and Developmental Disabilities

Subject to the availability of federal funding, S.B. 7 directed DADS to develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with IDD and behavioral health needs that are at risk of institutionalization. In addition, S.B. 7 directed DADS to establish one or more behavioral health intervention teams to provide services and supports to those same persons.

Many individuals with physical disabilities or IDD and individuals who are aging have co-occurring behavioral health needs. Nearly one third of the SSLC population has IDD and co-occurring behavioral health diagnosis (dual diagnosis) as do almost 90 percent of individuals admitted to SSLCs in the past two years. In addition, nearly one-fourth of individuals across all Medicaid IDD waiver programs have IDD and one or more co-occurring behavioral health diagnoses. Looking specifically at individuals receiving services through the HCS waiver, 36 percent of individuals have a dual diagnosis. Individuals with an IDD and co-occurring behavioral health diagnoses often face challenges to becoming fully integrated in their communities.

*Current Status*

**Transition Support Teams and Enhanced Service Coordination**

In March 2015, HHSC and DADS received approval from CMS for a three year grant to support a new initiative under the Texas MFPD to enhance services for individuals with IDD relocating from an institution by strengthening the infrastructure to enhance (1) medical, behavioral, and psychiatric supports, and (2) community coordination. This new funding makes available an array of safety net services and supports that assist LIDDAs and program providers in ensuring successful relocation of individuals into community settings. The LIDDAs are critical to these coordination and community preparedness activities; they have established eight regional medical, behavioral, and psychiatric support teams to conduct these activities. The goals of the teams are to provide the following support services to the 39 local authorities and service providers across all 254 Texas counties:

- Quarterly webinars, videos, and other educational activities focused on increasing the expertise of IDD local authorities and providers in supporting targeted individuals
- Technical assistance pertaining to specific disorders and diseases, with examples of best practices for individuals with significant challenges
- Case-specific support to service planning teams needing assistance, including addressing any unique regional and cultural issues and challenges, to provide effective care for an individual and reporting to DADS about any gaps in medical, psychiatric and behavioral resources

In June 2015, DADS contracted with eight LIDDAs to serve as regional fund administrators to address the distinct issues and challenges within the coverage area. The majority of teams became fully operational on September 1, 2015. Additionally, standardized reporting processes support the identification of systemic issues and potential solutions to be implemented at the regional or statewide level. The eight LIDDA regional teams will continue to provide these consultative services through the end of fiscal year 2017 with ongoing federal funding through the MFPD funds. On-going evaluation of outcomes associated with the activity of the teams will help identify gaps in medical, nursing, and nutrition management services, and behavioral and mental supports. This includes capacity of small residential settings to provide clinical, behavioral, and mental health support services and supports to individuals with the most complex needs.

DADS implemented enhanced community coordination services for individuals who have chosen to relocate from an institutional setting (i.e., SSLC or nursing facility) to a community Medicaid waiver program or community ICF-IID. The LIDDAs ensure:

- The individual and the individual's legally authorized representative are provided information about available community living options, services, and supports in addition to the information provided during the community living options process;
- The individual and legally authorized representative are provided opportunities to visit community providers;
- The individual is provided intensive and flexible support to achieve success in a community setting; and
- The individual is provided pre- and post-transition monitoring services as required by MFPD.

**Crisis Respite and Behavioral Intervention Teams**

The 84th Legislature, Regular Session, 2015, provided funding to support individuals with IDD and significant behavioral and psychiatric challenges, many of whom transitioned or were diverted from institutional settings. These individuals often exhibit significant needs requiring additional support beyond the array of services typically provided within community programs. The development of behavior intervention services and crisis respite programs across the state will provide assistance to individuals with IDD in crisis, allowing them access to temporary stabilization resources while identifying long term supports to meet their needs.

In 2016, DADS conducted a gap analysis to determine areas of the state lacking behavior intervention and crisis respite services including mobile crisis response units, 24-hour crisis hotlines, accessible community behavior support services, on-call programs, respite support

services, and psychiatric emergency services. Based on results of the gap analysis, DADS is establishing crisis intervention supports, including behavioral intervention supports and crisis respite programs at LIDDAs to provide supports for individuals with an IDD in crisis to have access to temporary crisis respite on a short-term basis while securing services that will meet their long term needs. Crisis support services were implemented in June 2016. These activities will be coordinated with local crisis support service efforts and the next steps will be consistent with the goals identified in the Texas Statewide Behavioral Health Strategic Plan, accessible online at: https://hhs.texas.gov/sites/hhs/files/050216-statewide-behavioral-health-strategic-plan.pdf .

Key components of the program include:

- Establishing, expanding, or enhancing community-based crisis services
- Providing support to existing crisis mobile units (such as a mobile crisis outreach team [MCOT]) to include the availability of a behavioral specialist who is specifically trained on addressing crisis situations with individuals with IDD
- Providing crisis respite services for individuals with IDD and for individuals who have IDD with co-occurring mental illness (MI), excluding MI only
- Providing follow-up care to monitor and provide support to individuals

**Web-based Training for Direct Service Workers on the Behavioral Health Needs of Individuals with IDD**

DADS contracted with The University of Texas Health Science Center at San Antonio (UTHSCSA) to develop web-based training that focuses on the behavioral health needs of individuals with IDD.

In October 2015, DADS released the first module in a six-part e-learning series titled *Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities*. The module focuses on the signs and symptoms of trauma, the impact of trauma on someone with IDD, and how to use a trauma-informed care approach. It is available to the public free of charge. The remaining modules became available in May 2016. DADS created a webpage for training initiatives that links to main training webpage: www.mhwidd.com.

The full curriculum for *Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities* contains the following six modules:

1. Co-occurring Disorders: Intellectual and Developmental Disabilities and Mental Illness
2. Trauma-informed Care for Individuals with IDD
3. Functional Behavior Assessment and Behavior Support
4. Overview of Genetic Syndromes Associated with IDD
5. Overview of Genetic Diagnoses Associate with IDD
6. Putting It All Together: Supports and Strategies for Direct Service Workers

## 6. Improve Access and Outcomes

*Promote Person-Centered Planning and Self-Direction*

Ongoing efforts to promote person-centered planning principles are occurring throughout the service delivery system. During the past year, DADS, in conjunction with the Institute for Person-Centered Practices, provided eight Person-Centered Thinking (PCT) workshops around Texas for LIDDA and program provider staff. PCT is the fundamental first step in providing the basic knowledge of person-centered planning and in facilitating the use of the tools to support others. Training locations included Austin, Dallas, El Paso, Fort Worth, Houston, McAllen, Odessa, and Seguin.

DADS and HHSC staff are working to develop a web-based training on person-centered planning which will be available in early fall 2016 to all who are interested. Specific target audiences include direct support workers and professionals, case workers, service coordinators, parents/guardians, and any other persons who are part of the life of an individual with disabilities. Goals of the webinar include making it available to all who would benefit from learning person-centered principles, improving the lives of individuals receiving services across the HHS system, and meeting the requirements of federal HCBS settings rules.

Person-centered planning is a process that empowers individuals and their legally authorized representative to direct the development of a plan of supports and services that meet their personal outcomes and goals by identifying the necessary supports and services, including natural supports. Person-centered planning focuses on individuals directing their service provision, meeting the goals and outcomes that are important to the individuals, including the people and supports chosen by the individuals and accommodating the individuals' style of interaction and preferences regarding time and setting.

Consumer direction of certain services is available in all of the Medicaid IDD waivers for those who live in their own homes. Individuals residing in HCS residential settings or DBMD assisted living settings do not have access to consumer directed services. Since consumer direction was expanded beyond services typically included in the residential rate, DADS[5] continues to explore the feasibility of offering certain consumer directed services, such as employment services, to waiver participants regardless of living arrangement.

*Information about Community Options and all Options*

To comply with H.B. 2276, 83rd Legislature, Regular Session, 2013, DADS created a pamphlet describing residential options for individuals titled, "*Residential Options for Individuals with an Intellectual Disability or Related Condition."* The pamphlet describes the types of services available in SSLCs, a community ICF-IID, and an HCS group home or host home/companion care setting. DADS is required to ensure each person inquiring about residential services receives information relating to whether appropriate residential services are available in each program or

[5] As of September 1, 2016, DADS community program staff are part of the Medical and Social Services Division of HHSC.

service for which the person may be eligible. DADS delegates this responsibility through contracts with LIDDAs. The LIDDAs are responsible for providing the pamphlet and an oral explanation to every individual and legally authorized representative who inquires about IDD residential services.

DADS provides funding to expand efforts to inform individuals and their families of community options through contracts with LIDDAs and other providers. For individuals residing in SSLCs, LIDDAs perform Community Living Options and Information Process (CLOIP) annually. For individuals residing in a nursing facility (NF), LIDDAs provide Community Living Options (CLO) information every six months, and contracted relocation specialists provide outreach activities funded by MFPD for residents who have indicated an interest in relocating to the community. Information brochures used during the CLOIP and CLO processes may be viewed at https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-and-developmental-disability-authority-lidda/community-living-options-information-process-cloip.

In July 2015, the Interagency Task Force for Children with Special Needs launched a new website created by parents for parents of children with disabilities and special health care needs. The site offers comprehensive, relevant, and reliable information for families, professionals, advocates, and anyone who works with children who have disabilities and their families. The website is available at the following link: navigatelifetexas.org.

DADS and HHSC continue to work with stakeholders to refine materials and outreach efforts to ensure all individuals are informed about appropriate community and service options.

*Quality Improvement*

DADS Community Services and Program Operations section[6] has two dedicated LIDDA curriculum developers who are developing both web-based and instructor-led training courses for LIDDA service coordinators. Six trainers have been hired. They are located across the state and have been meeting with their assigned LIDDAs to gather feedback on training needs and to schedule trainings. The first course, delivered in May and June 2016, is the CFC HCS and TxHmL service coordinators instructor-led training.

DADS initiated Quality Service Reviews (QSRs) in January 2015 to evaluate the implementation of Pre-Admission Screening and Resident Review (PASRR). Independent reviewers conduct interviews, review medical and service records, and make on-site visits to evaluate the extent to which the federal PASRR regulations, state rules, and LIDDA and provider performance expectations are being met. Seven DADS staff have been hired to create an internal QSR team; these staff are currently in training. Reviewers use a standardized evaluation process. Ratings are compiled to determine levels of compliance. A goal to achieve 85 percent compliance with all outcomes by the end of calendar year 2019, with all outcomes achieving sustained compliance for a full year by 2020, has been established.

[6] As of September 1, 2016, DADS community program staff are part of the Medical and Social Services Division of HHSC.

*Outcomes and Performance Measures*

DADS Center for Policy Innovation (CPI)[7] Quality Research and Reporting section monitors 204 performance measures for CMS. These performance measures provide feedback on 1915(c) waiver program performance and serve to drive improvements in service delivery over time. The measures fall under six broad assurance categories: Administrative Authority, Level of Care, Qualified Providers, Service Plan, Health and Welfare, and Financial Accountability. Additionally, the National Core Indicators (NCI) survey is used with individuals receiving LTSS on a biennial basis to track system performance in areas such as access to services, choice, and satisfaction with both services and service outcomes.

*HCBS Settings: New Federal Home and Community Based Services Rules*

In March 2014, a new federal rule became effective governing HCBS setting requirements, including individuals' right to privacy, dignity, respect, community integration, access to competitive employment, and optimization of individual choices concerning daily activities, physical environment, and social interaction. The new rule also includes expectations governing how states implement person directed planning. Additional information about efforts related to these new HCBS rules can be found in the CFC Education and Outreach and Person-Centered Planning sections of this report.

All states were required to submit a transition plan outlining the steps they will take to come into compliance with the regulations by 2019. HHSC submitted the statewide transition plan in December 2014 and a modified version which included a transition plan for the STAR+PLUS waiver in March 2015. Texas received feedback from CMS on the plan in September 2015 and HHSC, DADS, and DSHS worked together to address CMS comments and modify the plan accordingly. The revised statewide transition plan (STP) was posted for public comment. In October and November 2015, HHSC conducted stakeholder meetings in Lubbock, El Paso, Harlingen, Fort Worth, and Tyler to provide high-level information on the new regulations, status of survey tools, share CMS feedback on the STP, and obtain feedback from stakeholders. The STP public comment period closed on January 19, 2016. HHSC submitted the revised STP to CMS by February 1, 2016. CMS issued new feedback on the revised STP on June 7, 2016. HHSC and DADS are reviewing the feedback and working together to address comments from CMS.

HHSC and DADS have developed web-based provider self-assessment tools and face-to-face participant assessment tools (residential and non-residential) to help determine provider compliance with the new regulations. The surveys for DADS 1915(c) participants and DADS providers began to be administered in April 2016. The surveys for STAR+PLUS MCO service coordinators and providers began in June 2016, and STAR+PLUS participant surveys began in July 2016. DADS has finalized a contract with the Public Policy Research Institute at Texas A&M University to conduct the face-to-face participant interviews with individuals in 1915(c) waiver programs. HHSC has finalized a contract amendment with its external quality review

[7] As of September 1, 2016, DADS community program staff are part of the Medical and Social Services Division of HHSC.

organization, the Institute for Child Health Policy, to conduct the face-to-face participant interviews with individuals in STAR+PLUS.

*Employment Assistance and Customized, Integrated, and Competitive Employment*

**Employment First Task Force** - S.B. 1226, 83rd Legislature, Regular Session, 2013, established employment as the first and preferred option for working-age Texans with disabilities, and also established the interagency Employment First Task Force to promote competitive employment of individuals with disabilities with the expectation that individuals with disabilities are able to meet the same employment standards, responsibilities, and expectations as other working-age adults [Texas Government Code, Section 531.02448(a)]. The task force continues to meet at least quarterly to promote competitive employment for individuals with disabilities. The current goals of the task force are to 1) design an education and outreach process targeted at working-age individuals with disabilities, including young adults with disabilities, the families of those individuals, service providers, and state agencies that provide employment and other services and supports to individuals with disabilities, and 2) prepare its second report to the Legislature, Office of the Governor, and the Executive Commissioner, due in September 2016.

**Money Follows the Person Employment Pilot** - Consistent with Employment First, DADS is administering a five-year employment pilot designed to help individuals with disabilities achieve meaningful, competitive employment in an integrated community setting. DADS selected two LIDDAs (Bluebonnet Trails Community Services and Hill Country Mental Health and Developmental Disabilities Center) and one private HCS provider (Thomas and Lewin Associates) to participate in the pilot. These providers are implementing systems change, including Employment First policies, and practices that improve employment outcomes for individuals with disabilities.

For the purpose of this project, Employment First means competitive, integrated employment is the primary goal for individuals receiving public services regardless of type or level of disability. Competitive employment means the individual earns minimum wage or higher, or the prevailing wage paid to individuals without disabilities performing the same or similar work, whichever is higher. Integrated employment means individualized employment at a work site where the individual routinely interacts with people without disabilities (excluding the individual's work site supervisor or service providers), and does not include group work. Competitive, integrated employment can also include self-employment.

Participating providers are transforming their organizations from a reliance on day program services to community-based, integrated employment. The State Supported Leadership Network conducted site visits with the three providers and offered guidance in the development of provider work plans. An evaluation of the pilot activities will be conducted by the Texas Center for Disability Studies at the University of Texas to determine successful approaches to improving employment outcomes through organizational change activities. Evaluation activities will begin in the summer of 2016 and will conclude in the early fall of 2016.

## 7. Recommendations on Implementation of and Improvements to the System Redesign

The IDD SRAC voted to submit twenty legislative appropriations request recommendations to the TDHCA, DADS, DARS and HHSC. These recommendations are included in Appendix C and include initiatives around attendant recruitment, training, and retention, streamlining operational processes and systems, increasing employment and educational opportunities for people with IDD, bolstering transportation and housing services and options, and other efforts toward improving programs and services and enhancing the quality of life for individuals with IDD. These recommendations were submitted to agency leadership for consideration in the development of the legislative appropriations requests.

The IDD SRAC also submitted recommendations to the HHSC Executive Commissioner regarding the Network Access Improvement Program for individuals with IDD (Appendix B) and recommended changes to the STAR+PLUS enrollment packet (Appendix D).

The subcommittee vote to support the Children's Policy Council recommendation to reduce the MDCP interest list by allowing all children and young adults up to age 21 who receive supplemental security income and meet MDCP waiver eligibility to automatically receive MDCP services without spending time on the interest list (Appendix E) indicated this issue will continue be an issue of interest for committee members.

Future areas of focus for consideration by the IDD SRAC will include meaningful outcomes for Medicaid recipients using person-centered planning, individualized budgeting, and self-determination (including inclusion in the community).

HHSC will continue to work closely with the IDD SRAC to consult and collaborate on the initiatives outlined in S.B. 7 and H.B. 3523. Additionally, HHSC and DADS will continue to work with stakeholders, providers, individuals and any other interested parties.

# Appendix A: IDD SRAC Membership

| | | |
|---|---|---|
| Mr. Mickey Atkins | Austin | LTSS provider, Medicaid non-managed care |
| Mr. Clay Boatright, Chairman | Plano | Family member of an individual with IDD who receives waiver/ICF-IID services |
| Ms. Lynne Brooks | San Antonio | LTSS provider, Medicaid non-managed care |
| Mr. Ricky Broussard | Alvin | Individual with IDD and recipient of services under the waiver programs |
| Ms. Kay C. Carlson | Houston | Family member of an individual with IDD who receives waiver/ICF-IID services |
| Mr. John P. Delaney | Terrell | Representative of community mental health and ID centers |
| Ms. Susan Garnett | Fort Worth | Representative of community mental health and ID centers |
| Ms. Debbie Gill | Dallas | Family member of an individual with IDD who receives waiver/ICF-IID services |
| Mr. Gary Hidalgo | Beaumont | Representative of aging and disability resource centers |
| Ms. Jillana Holt-Reuter | San Marcos | Advocate of individuals with IDD who receive waiver or ICF-IID services |
| Ms. Katy Hull | Henderson | Individual with IDD and recipient of services under the waiver programs |
| Mr. Gerard Jimenez | Austin | Family member of an individual with IDD who receives waiver/ICF-IID services |
| Ms. Jean Langendorf | Austin | Advocate of individuals with IDD who receive Medicaid or ICF-IID services |
| Ms. Linda Levine | Bee Cave | Family member of an individual with IDD |
| Ms. Amy Litzinger | Austin | Individual with IDD and recipient of services under waiver programs |
| Ms. Janet Marino | McKinney | Representative of an MCO that contracts with the state to provide IDD services |
| Mr. Frank McCamant | Austin | Advocate of individuals with IDD who receive waiver/ICF-IID services |
| Ms. Susan Murphree | Austin | Advocate of individuals with IDD who receive waiver/ICF-IID services |
| Ms. Susan Payne | College Station | Family member of an individual with IDD who receives waiver/ICF-IID services |
| Ms. Mary Stephney Quinby | Rosenberg | Advocate of individuals with IDD who receive waiver or ICF-IID services |
| Ms. Leah Rummel | Austin | Representative of MCO that contracts with the state to provide IDD services |
| Ms. Carole Smith | Austin | LTSS provider, Medicaid non-managed care |
| Mr. David Southern | Granbury | Private ICF-IDD provider |
| Dr. Carl Tapia | Houston | Pediatrician with Texas Children's Health Plan |
| Ms. Cheri Wood | Tyler | Family member of an individual with IDD who receives waiver/ICF-IID services |
| Ms. Ivy Zwicker | San Antonio | Private ICF-IDD provider |

# Appendix B: IDD SRAC Network Access Improvement Program Recommendations Letter

February 24, 2016

Executive Commissioner Chris Traylor
Texas Health and Human Services Commission
4900 North Lamar
Austin, TX 78751

Re: Network Access Improvement Program (NAIP)

Dear Executive Commissioner Traylor;

The Intellectual and Developmental Disability System Redesign Advisory Committee (SRAC) would like to propose some recommendations for consideration to expand access to physicians for people with intellectual and developmental disabilities (IDD). The committee has several recommendations for consideration:

1. Encourage expansion of successful models of care by promoting expansion of Comprehensive Care Clinics and Transition Clinics throughout Texas. The Health and Human Services Commission (HHSC) can assist by consistently promoting and approving the Network Access Improvement Program (NAIP) proposed by Texas. The NAIP is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing health-related institutions (HRIs) and public hospitals to provide quality, well-coordinated, and continuous care. The committee strongly recommends HRIs and public hospitals to consider funding these clinics through-out Texas to assure access to persons with IDD and ensure the expertise to treat complex conditions for persons with multiple conditions. In addition, we recommend funding through the 1115 waiver projects through the Rural Health Programs to include expansion of the Comprehensive Care Clinics and Transition Clinics throughout Texas.

   Good examples of these types of clinics include "The Baylor Transition Clinic" https://www.bcm.edu/healthcare/care-centers/transition-medicine and the "Dell Children's Comprehensive Clinic" https://www.dellchildrens.net/services-and-programs/childrens-comprehensive-care-clinic/. Both clinics look at children or adults with disabilities on a more comprehensive basis and have expertise in treating persons with multiple conditions. Based on information presented in the STAR Kids Advisory Committee, these types of clinics have very favorable outcomes and should be considered as models with best practices for persons with intellectual and developmental disabilities.

2. The NAIP funding should include an educational component to provide incentive payments for additional physician training to serve persons with IDD and an enhanced payment for the additional time needed for certain complex cases.

3. The Committee requests that HHSC develop a comprehensive educational program for primary care and specialty physicians to better educate physicians to understand how to better treat their patients with IDD. The executive commissioner should identify areas where there is limited access to physicians throughout the state, work with specialty societies to determine how best to communicate to the physician and provide training, and determine how to provide expertise from expert physicians currently treating persons with multiple disabilities to be available for any questions and their expertise. This should begin to expand expertise throughout Texas of physicians willing to develop good clinical care for a more complicated population.

4. The Committee requests that HHSC develop a comprehensive educational program for primary care and specialty physicians to better educate physicians to understand how to better treat their patients with IDD. The executive commissioner should identify areas where there is limited access to physicians throughout the state, work with specialty societies to determine how best to communicate to the physician and provide training, and determine how to provide expertise from expert physicians currently treating persons with multiple disabilities to be available for any questions and their expertise. This should begin to expand expertise throughout Texas of physicians willing to develop good clinical care for a more complicated population.

   We appreciate your commitment to provide services for persons with IDD and look forward to Texas taking the lead in innovative solutions to better care and outcomes. If you have any questions please feel free to call.

   Sincerely,

   Clay Boatright
   IDD SRAC Chair

# Appendix C: IDD System Redesign Advisory Committee (SRAC) Legislative Appropriations Request Recommendations

The IDD SRAC developed the following 20 legislative appropriations request recommendations and submitted the recommendation to the following agencies, Texas Department of Aging and Disability Services (DADS), Texas Health and Human Services Commission (HHSC), the Department of Assistive and Rehabilitative Services (DARS), and the Texas Department of Housing and Community Affairs (TDHCA).

*Legislative Appropriations Request Recommendation 1*
**To: DADS and HHSC**

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**Individual/Organization: IDD SRAC**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee Chair**

**Phone number: 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue**:

The recommendation in this request is to address long standing challenges with attendant recruitment and retention and assure quality of and continuity in care in the delivery of LTSS to individuals with IDD.

Although not inclusive of all strategies to address the aforementioned issues, providers of LTSS for individuals with IDD need access to sufficient funds to provide enhanced staffing ratios and/or professional support for direct support staff such as when working with persons with high medical or behavioral challenges.

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**What is the critical need that needs to be addressed?**

Provision of Enhanced Support: When staff do not feel supported or are not provided the tools and training necessary to execute their responsibilities, not only are the health and safety of individuals placed at risk, but job satisfaction is adversely affected. The ability to provide enhanced support (whether through additional direct support staff or on-site training and coaching by certain professionals, such as in settings in which individuals with high medical or behavioral challenges reside) would contribute significantly to not only increasing attendant confidence and competence, but also in ensuring the health and safety of individuals being served.

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**Is this Issue/Initiative?** **_x___New** **____Expansion** **____Restoration**

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**Proposed Solution:**

Provide funds for LTSS providers of services to individuals with IDD to be able to provide enhanced staffing ratios and/or professional support for direct support staff such as when working with persons with high medical or behavioral challenges.

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**What do you recommend as a course of action?**

Request funds for providers to be able to provide enhanced staffing ratios or on-site professional coaching as needed. The funds requested could either be made available through a program similar to the current Attendant Compensation Rate Enhancement program or via a new add-on rate or program service rate for all IDD programs using attendant care for which evidence must be demonstrated and verified that the funds were used in accordance with their intended purpose.

*Legislative Appropriations Request Recommendation 2*
**To: DADS and HHSC**

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**Individual/Organization: IDD System Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue:**

Currently the system used by the state for billing and payment, service coordination and critical incident reporting is either outdated (Home and Community-based Services waiver CARE system) or paper-based (CLASS & DBMD). Therefore, substantial administrative time is spent by DADS, service coordinators, and providers in the exchange of information that should be seamlessly shared electronically. Systems currently operated in the fee-for-service program are also not interoperable with managed care organization systems creating barriers to the vision of a more streamlined acute and long-term care service delivery system.

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**What is the critical need that needs to be addressed?**

Using outdated systems includes other repercussions as well including:

- Difficulty gathering and analyzing useful, trendable data related to quality

- Additional regulatory time spent on-site analyzing information
- Several providers are not using encrypted e-mails, communications are often by fax or mail between entities
- Time that could be used for service coordination and direct provision of services spent on transferring documentation
- Delays in processing and implementation of plans of care and Medicaid eligibility due to human error
- Sharing information and coordinating care between entities caring for persons with IDD could be greatly improved.
- Assuring systems are HIPPA compliant.

With the transition to managed care, MCOs would benefit from more seamless data sharing.

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**Is this Issue/Initiative?** **_X___New** **____Expansion** **____Restoration**

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**Proposed Solution:**

The state must develop the capability to electronically maintain health and life records for all clients served in Long Term Services and Supports (LTSS) programs that are interoperable with related systems.

RATIONALE: Use of electronic life/electronic health records for LTSS programs will improve the quality of the programs, provide the state better data on the quality of programs, streamline communications and processes for eligibility and implementation of services, reduce administrative burdens of agency staff, service coordination staff, LTSS provider staff and managed care organization staff, and improve the quality of services delivered in the community.

Electronic Life Records/Electronic Health Record providers currently on the market include basic health and life records as well as additional modules that improve provider quality assurance through online staff training specific to individuals, critical incident reporting data trending, immediate notifications to nursing staff of potential errors by delegated staff.

Life records need to be available to consumers, MCOs and all parties involved and be on a shared platform.

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**What do you recommend as a course of action?**

Contract with an experienced vendor to replace other client management systems with a unified platform for the use of electronic health/electronic life record technology. Any system must be capable of interoperability between entities (managed care organizations), service coordinators, and long-term care providers.

Require and fund the use of electronic documentation by long-term care service providers.

*Legislative Appropriations Request Recommendation 3*
**To: HHSC and DADS**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue:**

Identify and develop health initiatives that address acute care health needs common to individuals with IDD.

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**What is the critical need that needs to be addressed?**

Individuals with IDD, as a group, are living longer and need the opportunity to age well; however, certain health conditions are common to individuals with IDD and could be reduced or managed if initiatives are developed to build capacity to maintain optimal health and avoid ER, hospital and institutional long term services and supports.

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**Is this Issue/Initiative? ____New __x__Expansion ____Restoration**

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**Proposed Solution:**

Expand quality based outcome and process measures to include health care concerns impacting individuals with IDD such as obesity (due to medications), recovery based mental health services for individuals with IDD and co-occurring mental illness, early onset Alzheimer's/dementia, heart disease, health literacy for self-care and decision making.

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**What do you recommend as a course of action?**

Analyze data and, if needed, expand data collection to include access, availability, experience, utilization, and the results of health care activities (outcomes) and patient perception of care related to health issues common to individuals with IDD. This will require data that sorts by disability such as IDD.

Provide bonuses or other incentives that demonstrate avoidance of potentially preventable health care events and management of chronic health issues specific to individuals with IDD.

Provide incentives for providing or arranging for health literacy training for individuals with IDD and their families so they can effectively engage in their own self care and health care decision making.

*Legislative Appropriations Request Recommendation 4*
**To: DADS and HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue:**
The committee is requesting funding to develop and implement a regional partnership throughout Texas for Local Intellectual Developmental and Disability Authorities (LIDDA), Medicaid managed care organizations, providers and persons with intellectual and developmental disabilities to better coordinate care for persons with IDD, to develop local solutions, develop strong partnerships resulting in better health outcomes for persons with IDD.

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**What is the critical need that needs to be addressed?**

Individuals with IDD may struggle to find services, receive coordinated care, understand benefits, develop a plan for the future, and have opportunities within the community including living in the least restrictive environment and working in an integrated setting. The IDD SRAC has recommended that Texas HHSC develop regional partnerships throughout the state of Texas. The goal is to have better outcomes for persons with IDD.

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**Is this Issue/Initiative? ____New __x__Expansion ____Restoration**

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**Proposed Solution:**

Develop and implement a regional partnership throughout Texas for Local Intellectual Developmental and Disability Authorities (LIDDA), Medicaid managed care organizations, providers and persons with intellectual and developmental disabilities to better coordinate care

for persons with IDD, to develop local solutions, develop strong partnerships resulting in better health outcomes for persons with IDD.

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**What do you recommend as a course of action?**

1. Funding support for staffing, securing locations for meeting and meeting materials are need to assure that the regional partnerships are developed and continue to operate.
2. Include funding recommendations as described above.

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*Legislative Appropriations Request Recommendation 5*
**To: HHSC and DADS**

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**Individual/Organization: IDD System Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue**: 2a

The recommendation in this request is to address long standing challenges CDS employers experience with attendant recruitment and retention and assure quality of and continuity in care in service delivery.

Although not inclusive of all strategies to address the aforementioned issues, CDS employers need access to sufficient funds to provide enhanced training and ongoing skill development including habilitation to attendants.

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**What is the critical need that needs to be addressed?**

Enhanced Training and Ongoing Skill Development: While access to funds to offer competitive and appropriate wages and benefits is an important factor, such is only one of numerous factors that impact recruitment and retention. The ability to offer enhanced training and ongoing skill development, including habilitation training, are equally important and would contribute significantly to not only increasing attendant confidence and competence, but also ensuring quality in service delivery.

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**Is this Issue/Initiative? __x__New ____Expansion ____Restoration**

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**Proposed Solution:**

Provide funds for individuals who self-direct their services to offer attendants enhanced training, including habilitation.

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**What do you recommend as a course of action?**

Request funds to support the ability of CDS employers to offer attendants enhanced training/ongoing skill development. The funds requested could either be made available through a 'program' similar to the current Attendant Compensation Rate Enhancement Program or via an add-on rate or program service for which evidence must be demonstrated and verified that the funds were used in accordance with their intended purpose.

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*Legislative Appropriations Request Recommendation 6*
**To: HHSC and DADS**

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**Individual/Organization: IDD System Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue**: (2)

The recommendation in this request is to address long standing challenges CDS employers experience with attendant recruitment and retention and assure quality of and continuity in care in the delivery of services.

Although not inclusive of all strategies to address the aforementioned issues, CDS employers need sufficient funds to offer competitive wages and benefits to both attract and retain attendants.

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**What is the critical need that needs to be addressed?**

Competitive Wages and Benefits: The inability of CDS employers to offer competitive wages and benefits continues to be a significant barrier in recruiting and retaining attendants and in ensuring continuity in the quality of services and supports individuals need. Turnover remains at high levels, resulting in gaps in the provision of needed services.

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**Is this Issue/Initiative?** **__x__New** **____Expansion** **____Restoration**

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**Proposed Solution:**

Provide funds for CDS employers to offer competitive wages and benefits.

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**What do you recommend as a course of action?**

Request funds to establish the Attendant Compensation Rate enhancement program in the CDS option. The funds requested must be sufficient to ensure all CDS employers participating in the Attendant Compensation Rate Enhancement program have access to the highest level and that the funding levels are equal to the parallel non-CDS programs.

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*Legislative Appropriations Request Recommendation 7*
**To: HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue:**

Expand physician and specialty capacity for persons with intellectual and developmental disabilities through adding funding of comprehensive care clinics and transition clinics.

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**What is the critical need that needs to be addressed?**

Individuals with IDD, as a group, are living longer and need the opportunity to age well. In addition, children and adults with IDD often have difficulties finding a medical home that understands their unique needs. A few exceptional clinics have been developed in Texas to address these needs Some examples of these types of clinics include "The Baylor Transition Clinic" https://www.bcm.edu/healthcare/care-centers/transition-medicine and the "Dell Children's Comprehensive Clinic" https://www.dellchildrens.net/services-and-programs/childrens-comprehensive-care-clinic/. Both clinics look at children or adults with

disabilities on a more comprehensive basis and have expertise in treating persons with multiple conditions. Based on information and testimony presented in the STAR Kids Advisory

Committee, these types of clinics have very favorable outcomes and should be considered as models with best practices for persons with intellectual and developmental disabilities. There are limited existing funding sources that can address development and expansion of Comprehensive Care Clinics and Transition Clinics. These include funding through Network Access Improvement Program (NAIP) funding and 1115 funding, however this funding has been limited while the need continues to grow. Because of the documented need for expansion of these programs and the limitation of available funding, the proposal for an exceptional item request is being made.

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**Is this Issue/Initiative? ____New __x__Expansion ____Restoration**

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**Proposed Solution:**

1. The IDD SRAC recommends the legislature fund Health Related Institutions (HRIs), public hospitals and other physician groups through-out Texas in a manner to assure access to persons with IDD and ensure the expertise to treat complex conditions for persons with multiple conditions. RATIONALE: The NAIP is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing HRIs and public hospitals to provide quality, well-coordinated, and continuous care. Some areas in Texas are interested in developing these type of specialty clinics, only lacking adequate funding, and we recommend additional state funding be provided to fund startup of these type of clinics. In addition, we recommend the 1115 waiver projects through the Rural Health Programs to include expansion of the Comprehensive Care Clinics and Transition Clinics throughout Texas.

2. The funding (recommended in number 1), should include providing incentive payments for additional physician training to serve persons with IDD and the development of an enhanced payment for the additional time needed for certain complex cases.

3. The funding (recommended in number 1) should include development of a comprehensive continuing educational program for primary care and specialty physicians to better educate physicians to understand how to better treat their patients with IDD.

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**What do you recommend as a course of action?**

1. Determine possible sites for comprehensive and transition clinics throughout based on areas where Texas has access to HRIs and RHPs who could utilize NAIP and 1115 funding and any additional state funding for start-up of these clinics.
2. Identify areas of state where access is limited for persons with IDD.
3. Determine amount of funding needed for a comprehensive education program.

4. Include funding recommendations as described above.

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*Legislative Appropriations Request Recommendation 8*
**To: DADS and HHSC**

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**Individual/Organization: IDD System Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue**:

The recommendation in this request is to address long standing challenges with attendant recruitment and retention and assure quality of and continuity in care in the delivery of LTSS to individuals with IDD.

Although not inclusive of all strategies to address the aforementioned issues, providers of LTSS for individuals with IDD need access to sufficient funds to provide attendants opportunities for enhanced training and ongoing skill development including habilitation.

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**What is the critical need that needs to be addressed?**

Enhanced Training and Ongoing Skill Development: While access to funds to offer competitive and appropriate wages and benefits is an important factor, such is only one of numerous factors that impact recruitment and retention. The ability to offer enhanced training and ongoing skill development, including habilitation training, are equally important and would contribute significantly to not only increasing attendant confidence and competence, but ensuring quality in service delivery as well.

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**Is this Issue/Initiative?** _x___**New** ____**Expansion** ____**Restoration**

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**Proposed Solution:**

Provide funds for LTSS providers of services to individuals with IDD to be able to offer attendants enhanced training, including habilitation.

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**What do you recommend as a course of action?**

Request funds to support the ability of providers to offer attendants enhanced training/ongoing skill development. The funds requested could either be made available through a 'program' similar to the current Attendant Compensation Rate Enhancement Program or via an add-on rate or program service for which evidence must be demonstrated and verified that the funds were used in accordance with their intended purpose.

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*Legislative Appropriations Request Recommendation 9*
**To: DADS, HHSC, and DARS**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Ricky Broussard, IDD SRAC, Day Hab and Employment subcommittee chair**

**Phone number: (Please include area code) 281-770-4599**

**Email Address: rickyinachair@yahoo.com,**

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**Description of Initiative/Issue:**

Competitive, Integrated Employment: Develop and/or expand individualized, person and community-centered approaches to competitive, integrated employment to include competitive wages and integrated settings.

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**What is the critical need that needs to be addressed?**

- Individuals with IDD, compared to individuals with other disabilities and individuals without disabilities, experience a higher rate of unemployment. Many of those with IDD who do work are often in segregated settings and are paid sub minimum wages.

- SB 1226, The Employment First Bill, addresses this need for competitive, integrated employment for all Texans with disabilities and it is yet to be implemented. The HCBS CMS settings rule also addresses this in regard to integrated services being required.

- Service plan implementation lacks flexibility to support individual choices related to competitive, integrated employment and volunteer and community exploration related to community jobs, in part due to the lack of providers of employment assistance and supported employment and transportation limitations. There needs to be a "pool" of trained service providers in order for consumers to access the services of employment assistance and supported employment. Although these services are offered, there is a serious lack of providers of these services

**Is this Issue/Initiative?** ____**New** __X__**Expansion** ____**Restoration**

**Proposed Solution:**

- Increase the number of individuals with IDD receiving employment assistance and supported employment services (VR, Medicaid waiver services of employment assistance and supported employment, state funded).

- Increase the percentage of waiver and other funds spent on competitive, integrated employment services relative to the percentage of dollars spent by all other day programs/services (documented as facility or community based) and segregated employment (such as sheltered employment or pre-vocational services).

- Increase flexibility of services and supports to better provide choice regarding competitively paid, integrated community employment (full or part time) that promote self-sufficiency and non-paid volunteer work that will lead to employment that allows meaningful contribution to the needs of one's community based on an individual's interests and preferences.

- Similar to HUBs for behavior, medical, psychiatric supports and consultation, a network of employment specialists could be developed starting with 8 specialists (1 per HUB) and gradually increasing to 1 per LIDDA.

- An increased provider rate is needed to provide employment assistance and supported employment to those with a higher level of need and support such as for those with behavioral needs.

**What do you recommend as a course of action?**

- Establish consistent rates, contracting structures, and performance measures with a clear intent of obtaining and maintaining competitive, integrated employment.

- Establish a rate structure that would provide a higher reimbursement rate for those with a greater level of need and/or supports.

- Promote awareness about how to obtain employment services and provide outreach and training to potential users and providers of employment services to include how to develop and implement an employment plan including exploring local job opportunities, negotiating job responsibilities, and providing ongoing or occasional supported employment job coaching.

- Create a transition plan to move away from individuals participating in facility based segregated work environments that pay subminimum wage.

- Create initiatives for employment assistance providers/counselors/specialists to be present in segregated work settings to establish ongoing relationships with the employees and assist them to transition to competitive, integrated employment (see Ohio's success with this strategy).

- Incentivize day hab providers, community rehabilitation providers, and other interested programs/parties providing services in segregated work settings to reallocate resources to competitive, integrated employment.

- Allow for flexible, individualized scheduling of preferred employment, employment exploration, and volunteer activities with supports, including staff, tailored to the person's individual needs. These services should be available during the weekday, evening, and weekends and also for individuals receiving residential services.

*Legislative Appropriations Request Recommendation 10*
**To: DADS and HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Ricky Broussard, IDD SRAC, Day habilitation and Employment subcommittee chair**

**Phone number: (Please include area code) 281-770-4599**

**Email Address: rickyinachair@yahoo.com,**

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**Description of Initiative/Issue:**

Self-determined, high quality of life

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**What is the critical need that needs to be addressed?**

- Individuals need to have their choice of services supported by high quality staff of their choosing who have ongoing training and adequate reimbursement/rates so they can support the individuals receiving services, and their relationships and goals.

- Individual's need more options in how they can be involved in choosing staff for all services received.

- Individuals need access to a reasonable amount of money to use, after paying room and board, for things that are not otherwise provided for or individuals will not be able to take care of their needs or afford to participate in community's activities.

**Is this Issue/Initiative?** **____New** **___x_Expansion** **____Restoration**

**Proposed Solution:**

- Expand requirements for and availability of person centered training so that the person(s) who work directly with individuals with IDD understand and provide the person centered supports the individual needs and wants.

- Expand consumer/self-direction so that individuals with IDD can make the decisions as to who supports them.

- Set a standard minimum personal spending allowance to be available to individuals after they pay room and board.

- Ensure the quality and continuous improvement of service planning so that Individuals don't remain in a subminimum wage job or volunteer job when they want to work for competitive pay or pursue other interests.

- In addition to competitive, integrated employment, a consumer may also be involved in volunteering.

- Ensure Individuals have access to reliable and accessible transportation that allows the individual to meet their employment goals.

- Pay competitive wages to staff who work with individuals both directly where they live and in the community (such as day services and employment services) so they don't have to leave for a higher paying job and so that they have the skills needed to support an individual according to their level of need.

- Allow staff to travel with the individual when they are out of the county, area, state, or country.

- Improve Texas National Core Indicators related to choice and control over an individual's services and daily life and any other areas of weakness.

- Include Post-Secondary Education as part of the person centered plan.

**What do you recommend as a course of action?**

- Involve the IDD SRAC in the National Core Indicators (and other performance measures) review and identifying strategies for areas of improvement within the subcommittee structures

- Require training on person centered approaches for staff who support individuals directly so they listen to, understand, respect, and support the individual's communication style; and advocate with and support the individual to participate fully in the community.

- Pay an increased rate for staff who need a higher skill set based on the individuals level of need (such as behavioral supports) and create a career ladder for direct care staff with increasing knowledge, skills and longevity. This increased pay rate, and setting a higher base pay rate requirement for direct support staff, will help individuals obtain and maintain staff and build good long-term working relationships with each staff and greater cooperation between staff persons.

- If needed to address medical or behavioral needs, allow individuals to have more than one staff to support them when needed for health, safety or integrated community activities.

- Goals may include retirement, recreation, employment, or community activities that happen in the weekday, evening, or weekends; therefore, a review of non-residential and residential models that support more individualization needs to start as soon as possible.

- Amend rules to ensure flexibility to allow staff to travel out of town, including out of state and the country.

- Require a review of the service plan annually with each individual to ensure inclusion and provision of requested services to increase independence.

- Expand consumer direction which would: (these items may take new funds or redoing rate structures to increase flexibility).

    - Allow individuals to exchange certain services in their service plan for other goods or services that help the individual have more person-centered services and a better quality of life;
    - Allow shared staff support, including but not limited to pooling day program resources, so that individuals receiving services who are interested in the same activities could do more activities that they choose, including participating with individuals who do not have disabilities in the community.
    - Allow individuals to decide who works with them, even if they don't fully self-direct their services and even if the staff support the individual in a group home or other residential service.
    - Develop a service delivery option (SRO) similar to what is available in STAR+PLUS Waiver that can be developed or modified for use in IDD Waiver programs so that, at a minimum, individuals are involved in interviewing and selecting staff who directly support them.
    - Train self-advocates in how best to choose staff and train the staff who work with them, whether using consumer direction or an agency provides my services

- Provide incentives to providers, such as a quality incentive program, that involves the individual choosing and training staff, extra training for providers, paying for the extra effort and time to listen to individuals receiving services.

*Legislative Appropriations Request Recommendation 11*
**To: HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee**

**Contact Person: Katy Hull, Susan Murphree, IDD SRAC, Quality subcommittee chair/co-chair**

**Phone number: (Please include area code) (903) 753-0723, 512 407-2754**

**Address: katyhull82@gmail.com; smurphree@drtx.org**

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**Description of Initiative/Issue:**

HHSC Utilization Management and Review SB 348 Dec. 2015 report identified quality concerns with MCO operations in Star +Plus. Some individuals with IDD are eligible for or receiving services as STAR+PLUS members and may be eligible for the STAR+PLUS waiver, but may not be identified as needing skilled nursing or other services.

Although certain training is available to MCOs and their contractors, it is not always required and the percentage of MCO staff and their contractors that have been trained is not known to the public.

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**What is the critical need that needs to be addressed?**

According to the report, all MCOs are utilizing the assessments and forms required by contract. However, the utilization reviews revealed opportunities for service coordination staff training related to appropriate completion of, and relationship between, assessment forms and service planning documents.

UMR data indicates a lack of MCO service coordinator understanding of the purpose of one of the required assessments (MN/LOC), and the identification of the member's skilled nursing needs, which is also an eligibility component for the HCBS STAR+PLUS waiver program. UMR determined the connection between skilled nursing needs identified on the MN/LOC and by the MCO registered nurse assessors' own documentation was broken. Skilled nursing needs were not appropriately addressed in the development of the ISP through the HCBS STAR+PLUS waiver program, or via informal supports, third-party resources, or other sources

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**Is this Issue/Initiative?** **____New** **___x_Expansion** **____Restoration**

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**Proposed Solution:**

Implement recommendation in the Dec. 2015 Senate Bill 348 Report and include additional stakeholder recommendations listed in the course of action section below.

Track and report training provided to MCO staff and contactors.

Recommend additional funding to support the HHSC and MCOs.

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**What do you recommend as a course of action?**

**Request funds to implement the following initiatives:**

- To improve their HCBS STAR+PLUS waiver assessment and service plan development by requiring MCOs to provide clear and consistent guidance to MCO staff on contract and HCBS STAR+PLUS waiver program policy requirements.

- Require and monitor implementation of a holistic nursing process for development of an ISP includes the assessments, an interview with the member/member's representative, and a thorough investigation of available resources to determining whether the members had needs which could only be met through the HCBS STAR+PLUS waiver.

- Require MCOs to report numbers or percentages of MCO staff and contractors that received training, for example, MCO service coordinators and contractors direct care staff trained on person centered approaches or trauma informed care. This data should be publically available on each MCO's report card and in MCO materials and on websites.

- Require use of accurate assessments for service planning and timeliness of the upgrades to the Star Plus waiver.

- Items and services requested by the member, or identified as a need in MCO documentation, must be addressed by the MCO.

- MN/LOC submittal, processing, and approval should be monitored by HHSC and the MCO to ensure no delay of upgrade or service for the member. The upgrade process, including identifying the need for upgrade, MN/LOC assessment, service plan development, and ISP posting, must meet the 45-day timeframe outlined in the Uniform Managed Care Contract (UMCC).

- Engage stakeholders, including SRAC representation, in service coordination improvement to ensure:
  - timely and adequate response to member's needs and change in health status;

- seamless care coordination and continuity of care (including when an individual with IDD transitions from an SSLC, ICF or NF to the community and is required to enroll in managed care and when a member changes MCOs);
- skilled nursing needs of members are appropriately assessed and met;
- evaluation and follow-up on service plans;
- coordinated access to an array of providers and third-party covered services; and
- technical assistance and training.

- Expand consumer assistance through access to a high quality, readily available and easily accessible ombudsman, preferably an independent ombudsman, to address managed care and other problems with acute and long term supports and services. Promote awareness of the ombudsman service.

*Legislative Appropriations Request Recommendation 12*
**To: DADS, DARS, and HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Ricky Broussard, IDD SRAC, Day Hab and Employment subcommittee chair**

**Phone number: (Please include area code) 281-770-4599**

**Email Address: rickyinachair@yahoo.com**

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**Description of Initiative/Issue:**
Competitive, Integrated Employment: Collaborate and expand partnerships to promote understanding and use of Social Security Administration (SSA) work Incentives, Vocational Rehabilitation services and Medicaid waiver Employment Assistance and Supported Employment services.

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**What is the critical need that needs to be addressed?**
Despite the availability of Social Security Administrations (SSA) initiatives, work incentives and the Ticket to Work program, these employment services remain underutilized nationally and in Texas, particularly for individuals with Intellectual and Developmental Disabilities (IDD).

Texas Medicaid waiver employment services of Employment Assistance and Supported Employment are grossly underutilized.

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**Is this Issue/Initiative? ____New __X__Expansion ____Restoration**

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**Proposed Solution:**

- Increase public awareness and provision of accurate information and assistance to individuals with IDD, families, legal representatives, supported decision makers, managed care companies, Local IDD Authorities (LIDDAs) and IDD providers regarding:
  - Plan for Achieving Self-Support
  - Impairment Related Work Expenses
  - Student Earned Income Exclusion
  - Ticket to Work
  - Employment services (employment assistance/supported employment) provided through Medicaid waivers
- Increase availability, accountability, and utilization of Medicaid waiver employment services.

---

**What do you recommend as a course of action?**

- Promote competitive, integrated employment by developing and/or expanding existing educational campaigns and other initiatives to not only increase awareness of work incentives and provide accurate information, but to also assist with applying for and implementing work incentives that allow individuals who receive SSI to exclude money, resources, and certain expenses from total earned income.

- Focus on training and providing resources for Local IDD Authorities, MCOs, and IDD providers, including on how to collaborate with local businesses, training about VR services, such as Ticket to Work and other support services that can be accessed through any participating employment network or state VR services so that the LIDDAs and providers can better assist individuals and their families and supporters to pursue person centered competitive, integrated employment goals.

- Require case managers to address employment goals at least annually for all consumers receiving services from a Medicaid waiver program.

- Better define expectations and success and implement systemic reporting so that statewide progress toward successful employment outcomes based on the employment goals can be recognized.

- Train IDD Medicaid waiver providers, day hab providers and other interested parties how to become successful employment services providers in order to have a "pool" of providers for employment assistance and supported employment services.

- We support the Employment First Task Force LAR for HHSC to have an Employment First division which will provide consumers with information and training in regard to competitive, integrated employment and will provide recruitment of employment services

providers as it relates to competitive integrated employment. This Employment First Division would be a centralized source of resources for employment related services and supports.

- HHSC will expand and enhance local employer recruitment training efforts to increase the employer base for those with disabilities.

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*Legislative Appropriations Request Recommendation 13*
**To: DADS and HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee**

**Contact Person: Katy Hull, Susan Murphree, IDD SRAC, Quality Subcommittee chair/co-chair**

**Phone number: (Please include area code) (903) 753-0723, 512 407-2754**

**Email Address: katyhull82@gmail.com; smurphree@drtx.org**

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**Description of Initiative/Issue:**

Ensure that day hab services are appropriately monitored and are providing appropriate quality services.

Fully implement a robust set of modifications to programs and services in order to comply with the Home and Community Based Services (HCBS) settings and person centered planning and services rules and guidelines from CMS.

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**What is the critical need that needs to be addressed?**
Day hab programs in Texas currently are facility based and not directly regulated or inspected for accessibility or physical environment. No standard requirements are in place so that day hab programs can improve services although some have expressed wanting to get more ideas and improve their services. Add minimum standards for day habilitation and pre-vocational settings to ensure quality services are provided.

Debarring an HCS/TxHmL and other IDD service providers from operating in Texas is not currently a regulatory option.

Texas needs to significantly improve services to individuals with disabilities to fully comply with HCBS settings and ensure that individuals with disabilities have access to the general community.

Ensure provider capacity and choice of provider as required by state and federal law because, in some community based services and programs, there are not enough qualified providers.

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**Is this Issue/Initiative?** **____New** **__X__Expansion** **____Restoration**

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**Proposed Solution:**

Require day hab and pre-vocational programs funded with home and community based dollars to register and set standard expectations, and at least annually ensure that a site visit is conducted by a regulatory entity.

Increase regulatory options in HCS/TxHmL, CLASS and other programs serving individuals with disabilities.

Effectively recruit providers known to be in limited supply so that there are no access to care barriers.

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**What do you recommend as a course of action?**

With diverse stakeholder input, create day hab standards and adequate resources that provide incentives.

Require day hab and pre-vocational programs to register. Don't allow non-registered day habs to contract with DADS/HHSC or IDD waiver providers.

Increase funding for day habilitations as they transition into fully integrated day services.

Increase opportunities for quality, person centered day and pre vocational services to implement HCBS settings and person centered approaches.

Directly regulate day habs and, at least annually have onsite inspections (similar to residential reviews).

Add day hab operations to the searchable QRS system, using a scoring system created with stakeholder input.

Develop and implement strategies to recruit additional Medicaid waiver and specialty providers, such as DBMD providers, specially trained medical and behavior providers (including but not limited to BCBAs), entry level direct care staff and new providers interested in servicing individuals with disabilities in the community. This could be a collaborative effort of MCOs and state agencies, not limited to managed care.

Add debarment to regulatory, contract enforcement options for HCS/TxHmL and expand contract termination as allowable across contract areas when significant quality concerns are evident or highly predicted in the short term in more than one contract area.

Create technical assistance resources for day habilitation and pre-vocational providers.

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*Legislative Appropriations Request Recommendation 14*
**To: DADS, DARS, and HHSC**

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**Individual/Organization: IDD System Redesign Advisory Committee**

**Contact Person: Susan Murphree, IDD SRAC, Quality subcommittee co-chair**

**Phone number: (Please include area code) 512-407-2754**

**Email Address: smurphree@disabilityrightstx.org**

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**Description of Initiative/Issue:**
Need for accessible, available, and appropriate transportation that is reliable so individuals with disabilities are able to get into the community for employment, service appointments or for recreational purposes

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**What is the critical need that needs to be addressed?**

- People with disabilities need to be able to use accessible, available, and appropriate public transportation all days of the week, including weekends. While this may be available in some metropolitan areas, it is largely lacking in more rural areas.

- Individuals using transportation services through 1915(c) waivers often are not able to use accessible, available, and appropriate transportation when it is needed to get into the community to access services, get to employment, or for recreational purposes. Staff are not allowed to transport individuals in their personal vehicles, which limits transportation options for individuals.

- Processes for scheduling transportation are complicated, and often do not allow people the flexibility required to meet their changing schedules.

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**Is this Issue/Initiative? _X___New ____Expansion ____Restoration**

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**Proposed Solution:**
Build a network of transportation professionals who can provide accessible, available, and appropriate transportation for people with disabilities

Develop a certification or licensing process so waiver providers can transport individuals in their personal vehicles.

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**What do you recommend as a course of action?**

Community Transportation Assistance Program (CTAP) –
CTAP would work to build a network of transportation professionals and support community transportation that makes community services and access to the general community accessible through *safe* and *affordable* transportation services for all requiring different individualized means of transport; not limited to professional appointments and work, but to include personal means of transport such as religious gatherings, Special Olympic practices/meets and many other community based social activities.

Expand access to the greater community by researching current transportation options and analysis of transportation unmet needs for individuals with IDD and other disabilities as well as a report of the percentage of individuals with disabilities whose needs for individualized transportation are being met based on their experience, survey, and/or data. It has been reported that gaining access to public transportation often requires reservations being made weeks in advance. An example has been made of getting to a doctor visit and the physician stating a follow up requirement within weeks. Individuals with disabilities often express concerns due to the length of time it currently takes to simply access appropriate transportation.

Create additional accountability available to individual caregivers, *either personal or residential*, to gain special licensing in order to transport persons with disabilities in their personal vehicles with some form of possible compensation. Though some waiver programs have transportation options, many do not have the staffing nor vehicle access to gain accessible, availability, nor appropriate transportation to the individual based on their person centered goals. It may be advantageous for the state of Texas to offer individual family, friends and paid caregivers an option to take a special driving course to include various special needs basics such as CPR, wheelchair tie-downs, not leaving individuals in vehicles unattended or in inclement weather, etc., opening up added means of transportation to individuals.

HHSC should conduct a comprehensive study of transportation issues, researching the impact on people with IDD.

Case Managers and Service Coordinators are knowledgeable and assist individuals with disabilities to understand and access transportation options

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*Legislative Appropriations Request Recommendation 15*
**To: DADS**

**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Kay Carlson, IDD SRAC Housing subcommittee chair**

**Phone number: (Please include area code) 281-495-9104**

**Email Address: kay.carlson@sbcglobal.net**

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**Description of Initiative/Issue:**

Strategies to address the lack of affordable housing options and opportunities for individuals with IDD.

- Create Housing Transition Specialist to assist people with intellectual and developmental disabilities transition to the most appropriate housing for the individual.

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**What is the critical need that needs to be addressed?**

1. There is no assistance available for individuals with IDD to consider available to help them find the best housing solution. Assistance to find appropriate housing can be funded as a Medicaid waiver benefit.

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**Is this Issue/Initiative?** _X__**New** **____Expansion** **____Restoration**

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**Proposed Solution:**

Funding for Housing Transition Specialists to assist consumers and families, case managers, service coordinators and low income individuals with intellectual and developmental disabilities transition and provide housing related services.

**What do you recommend as a course of action?**

Request appropriation and legislative approval to fund a Medicaid waiver benefit of Housing Transition Specialists.

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*Legislative Appropriations Request Recommendation 16*
**To: DADS and HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Ricky Broussard, IDD SRAC, Day Hab and Employment subcommittee, chair**

**Phone number: (Please include area code) 281-770-4599**

**Email Address: rickyinachair@yahoo.com**

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**Description of Initiative/Issue:**
Currently, individuals with IDD receiving day hab (prevocational) services do not have full access to the greater community through their home and community based (HCBS) services.

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**What is the critical need that needs to be addressed?**

- Service delivery design and reimbursement rates are barriers to individualized, integrated community participation, making person centered plans and implementation plans hard to fully implement.

- Community First Choice, combined with Supported Home Living transportation services, provide some flexibility to meet individualized goals for individuals living in their own/family home. CFC or a similar hourly service (perhaps with CLASS pre-vocational services rates as an example) is not available to individuals receiving HCS residential services.

- Individuals, regardless of where they live, who receive day hab services get the services primarily in facility settings with no or limited access to the community during day hab services.

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**Is this Issue/Initiative? ____New __X__Expansion ____Restoration**

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**Proposed Solution:**

- Provide/expand flexible community supports, similar to CFC, during the weekday when a person would otherwise have been receiving day hab services, according to the person's choices and person centered plan. CFC is not duplicative of residential services if provided during the hours not covered by residential supports.

- Adjust rates based on level of support needs. Work with stakeholders to design a phased in, reasonable approach over the next few years.

- Provide incentives for reallocation of resources and creative models that improve access to the greater community during weekdays, evenings, and weekends. Staffing and transportation or a transportation plan will likely be needed. Making new or maintaining existing relationships should be supported within the model.

- Increase day program community participation over a few years to achieve at least 51 percent of an individual's time, on average, spent accessing the greater community according to the individual's goals and preferences.

- Continue to utilize the Day Hab and Employment Subcommittee of the IDD System Redesign Advisory Committee as the designated committee to develop ideas, review other state's day and employment services, and provide stakeholder feedback as the state moves from segregated day services to integrated, fully community-based activities.

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**What do you recommend as a course of action?**

- Pilot or phase in flexible community supports/CFC in one or more local authority area for individuals who want to increase community participation as a full or part time alternative or as a compliment to employment, volunteering or facility-based day services, including individuals receiving residential services.

- Develop and promote pooling of day services dollars to participate in shared interests in the community for up to 3 individuals to provide staff and transportation.

- Provide funds to incentivize or reward creative service models that increase flexibility to support individualized, person-centered, lifespan goals including competitive, integrated employment, integrated retirement, community recreation, and learning opportunities available in the greater community and that provide planning assistance and other supports that are available at various times, not limited to weekdays, adjusted for level of support needs of participants.

- Provide access to SHL/transportation services to support community participation, including individuals receiving residential services during times residential services are not provided.

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*Legislative Appropriations Request Recommendation 17*
**To: DADS, HHSC**

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**Individual/Organization: IDD System Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC Transition to Managed Care subcommittee chair**

**Phone number: 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

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**Description of Initiative/Issue:**

Expanded behavioral health resources for people with intellectual and/or developmental disabilities.

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**What is the critical need that needs to be addressed?**

There is a dearth of providers trained in serving the behavioral health needs of people with IDD. Even for people who have financial resources such as commercial insurance or access to comprehensive services through a Medicaid program, it is difficult or impossible to access qualified practitioners. The challenge is even greater for people who are uninsured on interest lists waiting to access comprehensive services. People with IDD and behavioral health issues need access to qualified health care practitioners AND specialized resources such as respite and resource centers, highly trained behavioral analysts, family education and supports, in-home assistance, etc. These resources need to be strategically placed across the state to meet the needs of the diverse population, including through the use of technologies like telehealth.

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**Is this Issue/Initiative? ____New __X__Expansion ____Restoration**

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**Proposed Solution:**

Expand current programs AND create new comprehensive programs. Programs, at a minimum, should include:

1. Evaluation and assessment to identify medical, psychiatric, and environmental factors
2. Coordination between the supports for the person including providers, family, specialized behavioral health supports
3. Crisis respite services that allow for alternatives to hospitalizations and also allow for planned respite for evaluation purposes
4. Training and consultation from highly trained clinical staff
5. Training for IDD providers
6. Training and consultation for behavioral health systems in the specialized needs of the IDD population
7. Availability of follow-up services to maintain progress
8. Development of cross-system crisis prevention and interventions to assure providers and families have options that limit the inappropriate use of police and emergency rooms for behavior interventions

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**What do you recommend as a course of action?**

The development of comprehensive initiatives to meet the behavioral health needs of people with IDD, enhancing current programs where available and developing new programs when necessary. Program should be comprehensive in nature, from out-of-home options to in-home supports. Texas should support the development of a model program for meeting the behavioral health needs of people with IDD.

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*Legislative Appropriations Request Recommendation 18*
**To: DADS, HHSC**

**Individual/Organization: IDD System Redesign Advisory Committee (SRAC)**

**Contact Person: Leah Rummel, IDD SRAC, Transition to Managed Care subcommittee chair**

**Phone number: (Please include area code) 512-263-0772**

**Email Address: leah_c_rummel@uhc.com**

**Description of Initiative/Issue**

The recommendation in this request is to ensure CDS employers have the skills and necessary information to practice training new and current employees.

**What is the critical need that needs to be addressed?**

Employer Training and Skills Practice: Employers under CDS need to receive additional information and hands-on opportunities to train new employees. This is especially important for young adults who are becoming their own CDS employer. Although they are their own guardian, a young person or new CDS employer may not have had an opportunity to interact as an employee or employer in the workplace. Extra training may be needed to enhance managerial skills, such as interviewing, hiring, training, addressing problems, or terminating employees.

**Is this Issue/Initiative? __x__New ____Expansion ____Restoration**

**Proposed Solution:**

Provide funds for CDS employers to have opportunities for enhancing managerial skills, as they relate to training, etc.

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**What do you recommend as a course of action?**

Request funds for CDS employers to be able to learn and enhance managerial skills, such as interviewing, hiring, training, addressing problems, or terminating employees.

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*Legislative Appropriations Request Recommendation 19*
**To: DADS**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Katy Hull, Susan Murphree, IDD SRAC Quality Subcommittee chair/co-chair**

**Phone number: (Please include area code) (903) 753-0723, 512 407-2754**
**Email Address: katyhull82@gmail.com; smurphree@drtx.org**

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Timely access to IDD waivers is limited. Waiting lists are long. Diversion and transitions are needed to prevent unnecessary institutionalization.

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**What is the critical need that needs to be addressed?**

Timely access to comprehensive waivers.

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**Is this Issue/Initiative? ____New _X__Expansion ____Restoration**

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**Proposed Solution:**
Fund waiting list reduction and promoting independence slots for diversion and transition. Implement no waiting list for SSI recipients when expanding managed care to new LTSS populations.

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**What do you recommend?**

**Fund waiting list reduction at least by 10 percent per year of the biennium.**

**Fully fund all Promoting Independence related transition and diversion waivers.**

If and when additional LTSS services are added into managed care over the next decade, eliminate the LTSS waiting list for SSI recipients eligible for those programs and fund that initiative

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*Legislative Appropriations Request Recommendation 20*
**To: DADS and HHSC**

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**Individual/Organization: IDD Systems Redesign Advisory Committee (SRAC)**

**Contact Person: Katy Hull, Susan Murphree, IDD SRAC, Quality subcommittee chair/co-chair**

**Phone number: (Please include area code) (903) 753-0723, 512-407-2754**

**Email Address: katyhull82@gmail.com; smurphree@drtx.org**

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**Description of Initiative/Issue:**
Capacity for assessing needs and assigning an appropriate level of need and resources is critical to individuals and providers so that individuals can live and receive high quality services in the most integrated setting.

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**What is the critical need that needs to be addressed?**
IDD assessments must become more comprehensive and the payment level sufficient to achieve and maintain optimal health, quality of life, and community living,

Group homes lack enough evening and weekend staff to increase community participation in residents' preferred activities;

Retirement options are lacking for individuals with IDD;

Enhanced services and add-on rates for more complex services, service coordination, and monitoring are not available to individuals with complex needs entering from the interest lists as well as those transitioning from an institution to the community.

Behavior support professionals are in short supply, causing delayed assessment and services, which can lead to more restrictive, out of home placements.

HCS providers have been dropping out of the program, not always due to quality issues;

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**Is this Issue/Initiative? ____New __X_Expansion ____Restoration**

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**Proposed Solution:**

Determine the most appropriate assessment and resource allocation or improve and modify the ICAP.

Assess and address the need for enhanced, high needs services regardless of one's entry to the waiver.

Address barriers for individuals with high needs that result in difficulty accessing home and community based programs and services.

Require HCCSAs to show best efforts to the individual and the agency if they are unable to meet a need.

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**What do you recommend as a course of action?**

**Note: These suggestions are for all IDD programs and, as appropriate, replication in other programs servicing additional disability and aging populations, not limited to IDD.**

Immediately change the grading/scoring of the ICAP so that an individual needing behavior supports is not required to already have a behavior management plan in place.

Expand the IDD Assessment Pilot to include additional InterRAI modules based on the individual's needs, including, but not limited to: intervenor supports, medical, behavioral, psychiatric and other needs. While the pilot focuses on individuals with IDD, it is a tool purported to be useful across-disability and aging populations.

Because providers have been reluctant or unwilling to take on the liability of serving an individual due to medical or behavior acuity (high needs), ensure that payment is both justified and sufficient and that providers that overtly or covertly delay or deny services to certain high needs individuals face enforcement actions.

Current efforts under consideration now to serve high medical and behavior needs of individuals with IDD should be funded, implemented, and sustainable. Enhanced services and add-on rates for more complex services, service coordination, and monitoring should be available to individuals with complex needs entering from the interest lists as well as those transitioning from

an institution to the community. Enhanced services for high needs individuals could benefit additional disability and aging populations and could be replicated with DSRIP funds, grants, or additional appropriations.

Continue to expand the behavior, medical, and psychiatric HUBS and other recent efforts such as crisis respite and include focus on preventing crisis and supporting families and providers of individuals who are at risk of placement in more restrictive settings. Include building capacity through recruitment of all levels of behavior clinical assessments and interventions, so individuals can find and obtain the clinical and other behavior supports they need within their homes, local communities, and regions in a timely manner.

Additional effort to provide payments for high medical needs should be implemented across programs-for the most medically involved individuals at risk of hospitalization. In HCS, a high medical level of need (similar to LON 9 for behavior supports) should be developed, especially considering that some of individuals also require and benefit from community based residential supports. This cost effective expansion of high medical needs initiatives can prevent a more restrictive, more expensive setting at a higher level of care.

LON 9 should be modified to address the need for 1:1 staff beyond aggressive behavior supports and supervision to include any behavior that is life threatening or puts a person at risk of physical harm and requires the same level of supervision and intervention.

Create due process rights so individuals and their representatives, not just providers, have the right to appeal a level of need determination. Ensure that UR recognizes the influx of individuals with more significant needs in to waivers and that not everyone is a LON 5. Implement a one year presumptive LON 6 or 9 for individuals enrolling from other institutional settings or aging out from CCP skilled nursing, not limited to SSLCs as is the current policy.

LIDDAs, individuals, and families should have all relevant information related to a decision by Utilization Review not to accept the LIDDAs LON recommendation and the right to appeal to a higher authority.

Provide, pay for group homes staffing for evening and weekend to increase community participation in residents' preferred activities.

Develop retirement options lacking for individuals with IDD who choose to retire based on stakeholder input (with significant input from self-advocates age 50+) and ensure that CFC and IDD service direct care staff and service coordinators are fully trained on person centered approaches. This will help not only with identifying goals, preferences and needs of aging individuals with IDD, but also ensure that person centered approaches result in desired outcomes for individuals of all ages receiving services.

# Appendix D: IDD SRAC Transition to Managed Care Subcommittee Recommended Changes to the STAR+PLUS Enrollment Packet

Recommended changes to the Managed Care Enrollment Packet for Individuals with Intellectual and Developmental Disabilities:

- Place the section about ways to get help, including availability of home visits to assist with enrollment, earlier in the letter in case individuals become confused in earlier steps.

- Make sure font is appropriate size and accessible.

- Separate the packet into separate English and Spanish packets. Send them both together, but no documents with English on one side and Spanish on the other.

- Include a chart differentiating Medicaid services available across all services, value added services and extra services. *NOTE: The comparison charts included are the standard comparisons that are on the HHSC website, so if the committee wants to make recommendations, it will be recommending changes to the standards for everyone.*

- Explicitly state who is and who is not eligible for everything on each of the sheets, so those who receive the letter in error will know quickly. Add a similar statement on the STAR+PLUS flyer.

- Mental Health Insert - Benefits for Mental Health Issues or Problems with Drugs and Alcohol
  - Change title to STAR+PLUS Benefits for Mental Health Issues or Problems with Drugs and Alcohol.
  - "All STAR+PLUS medical plans offer help for mental health issues or problems with drugs and alcohol. You can get help if you have any of these problems." This language is misleading.
  - This is the same benefit across managed care organizations, so statement about deciding which managed care organization meets your needs is confusing.

- Move "What is STAR+PLUS?" page closer to the front of the packet.

# Appendix E: IDD SRAC Quality Subcommittee Recommendation to Support the Children's Policy Council's Medically Dependent Children Interest List Reduction Recommendation

**Children Belong in Families: Nursing Facility Diversion and Promoting Independence**

When children have needs that go beyond what their families can meet, sometimes families must place their children into nursing facilities or other institutions. In many cases, placement outside the home can be avoided and families can remain together if families have access to critical supports such as waiver services, personal care services, and private duty nursing. If out of home placement is ever needed, children should be supported in families instead of facilities.

**Policy Issue: Medically Dependent Children Program (MDCP) Interest List Reduction**

As of January 31, 2016, a total of 18,615 children and young adults were on the interest list for the Medically Dependent Children's Program (MDCP) waiver[8]. A wait of approximately four to five years to receive services can have serious consequences for children with complex medical needs and their families. With the implementation of STAR Kids in November 2016, Texas has an opportunity to significantly reduce the MDCP interest list by allowing all children and young adults up to age 21 who receive supplemental security income (SSI) and meet MDCP waiver eligibility to automatically receive services with no wait. Texas implemented a similar initiative for adults when the STAR + PLUS waiver rolled out and as a result, has virtually eliminated the interest list for adults. Children who qualify for a Medicaid waiver in lieu of receiving services in a nursing facility should have similar access to services as those guaranteed to an adult.

**Recommendation**

1. **Divert children from nursing facilities** by allowing all children and young adults who have SSI and meet the MDCP eligibility criteria entry into the waiver services in STAR Kids or STAR Health with no wait. For those individuals who are on the waiting list and who do not have SSI, maintain at least the same level of effort to offer those individuals waiver services at the same rate.

**Background**

Children who qualify for a Medicaid waiver in lieu of receiving services in a nursing facility should have similar access to services as those guaranteed to an adult. When the STAR+PLUS waiver rolled out in Texas, adults who had SSI and qualified for the STAR+PLUS waiver received services with no wait. This practice has virtually eliminated the interest list for adults who qualify for the nursing facility waiver and has assisted individuals to stay in their homes and communities. STAR Kids will begin in November of 2016. Children and young adults with SSI or who are served by 1915(c) waivers will enroll in the STAR Kids Medicaid managed care plan to receive their acute care services and some long-term services and supports, like personal care services and private duty nursing. Children on the MDCP waiver will also receive their waiver

[8] Health and Human Services Commission. (2016). Report to the Promoting Independence Advisory Committee.

services through STAR Kids. With the change in service delivery model for MDCP, Texas has not changed the number of appropriated "slots" for the waiver. As such, entry to the waiver still will be managed by an interest list. Unlike STAR+PLUS waiver, children and young adults who have SSI and meet MDCP eligibility criteria may not access waiver services until they come to the top of the interest list. MDCP services, which can help prevent institutionalization, include: respite, minor home modifications, adaptive aids, flexible family supports, financial management, transition assistance services, supported employment, and employment assistance. The historical take-up rate in the MDCP waiver is 10.4 percent.[9] Therefore of the 18,615 individuals on the interest list only 1,936 people will be deemed eligible and accept services when offered. Of the 1,936 individuals, approximately 1,000 have SSI. Implementing this recommendation will make a significant difference in quality of life for families and will drastically reduce the MDCP interest list.

**How much would it cost to meet the needs of children who need a nursing facility level of care in their homes?**

**Scenario 1: Providing MDCP services to individuals on interest list who meet nursing facility level of care and have SSI**

| | Eligible per Month | Total Annual Cost AF | Total Annual Cost GR |
|---|---|---|---|
| **FY2018** | 1,121 | $20,000,000 | $8,764,000 |
| **FY2019** | 1,164 | $21,000,000 | $9,202,200 |
| **Biennial** | | $41,000,000 | 17,966,200 |

**Scenario 2: Providing MDCP services to individuals on interest list who meet nursing facility level of care, regardless of SSI**

| | Eligible per Month | Total Annual Cost AF | Total Annual Cost GR |
|---|---|---|---|
| **FY2018** | 2,107 | 113,000,000 | 49,516,600 |
| **FY2019** | 2,188 | 117,000,000 | $51,269,400 |
| **Biennial** | | 230,000,000 | $100,786,000 |

Note: analysis assumes a start date of September 2017
Source: HHSC System Forecasting, April 2016

**Policy Issue: Getting and Keeping Children out of Institutions**

Access to community-based waivers has allowed children to grow up in loving and well supported families, has saved the state money, and has contributed to rebalancing the Texas long term service and support system. This work should continue and be expanded to those who have not yet been included.

[9] Texas Department of Aging and Disability Services. (2016). House Committee on Appropriates Subcommittee on Article II Charge #10.

**Recommendation**

2. **Fully fund Promoting Independence initiatives** for children including waivers to support children to move from facilities and to divert children from admission.

It is the policy of the state of Texas that children belong in families. For many years now, the Texas Legislature has funded waivers to support children to move from facilities and to divert them from facility admission as part of its commitment to Olmstead and the Texas Promoting Independence Plan. The number of children and young adults growing up in nursing facilities has decreased by approximately 72 percent.[10]

The Texas Legislature has historically funded the following waiver services:

- For 500 individuals to move from large or medium ICF-IIDs.
- For 216 children aging out of DFPS foster care.
- To prevent institutionalization in SSLC due to crisis for 400 individuals.
- For children living in DFPS General Residential Operations. The historical number is 25. This needs to be increased to 35.
- To assist 120 individuals to move from state hospitals, and most recently.
- To divert children from admission to nursing facilities.

[10] Health and Human Services Commission. (2015). Permanency Planning and Family-Based Alternatives Report.